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SOCIAL WORK is a professional journal committed to improving practice and extending knowledge in the field of social welfare. The Editorial Board welcomes manuscripts that yield new insights into established practices, evaluate new techniques and researches, examine current social problems, or bring serious, critical analysis to bear on the problems of the profession itself. The occasional literary piece is gladly received when it concerns issues of significance to social workers.

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Editor's Page

By 1961 the first wave of comment on the Curriculum Study[1] will be over. Its report has been reviewed by a number of important journals, discussed in NASW chapters, committees, and workshops—in some instances more reacted to than read! This journal had hoped with this current number to have an interpretive report from the practitioner constituency—based in part on the responses of over 40 chapters to questions posed by the NASW Commission on Education—but as yet there is too wide a range of opinion for analysis.

The Curriculum Committee of the Council on Social Work Education, under the leadership of Dr. Helen Wright, undertook a conscientious analysis of all thirteen volumes, coming out with several preliminary conclusions. In effect, these rejected (1) the idea of a "continuum" of graduate-undergraduate professional education; (2) the proposals for a "practicum," and (3) a different approach to the teaching of foundation knowledge and methods courses—thus reaffirming the 1952 Curriculum Policy Statement. Although a good word was said by the committee for experiments *within accepted curriculum policy,* the climate was somewhat less than enthusiastic.

While both the council and chapter committees found much to affirm and more to test, the major propositions of the Curriculum Study seem stubbornly unacceptable. Looking back over the years of curriculum investigation, it is apparent that educational structure is enormously difficult to modify, backed as it is by habit, university regulations, and accreditation procedures. But perspective reveals also that within a given framework there is far greater disposition today than in the past to allow for variation as to individual student aptitude and program flexibility. This at least is encouraging for the future of professional as well as general education.

The publication of an over $300,000 educational project prompts some inevitable questions. For the reader of this journal surely one of the more important criteria in the study of professional education is practice. Yet why did neither the Hollis-Taylor report[2] nor this study make a substantial inquiry into practice, at least through the characteristic established courses in field work?

Why did this study have to be made before the NASW Commission on Practice was operative? It is true that most professional school curricula have been moving away from the older emphasis on skill in practice to "knowledge" and social work is no exception. But one result is that the gap between school and field has never been so wide. Pressure from new fields continues, but how far have we gone in defining the generic and specific in learning? How effectively is learning financed by lobby opposed? For nearly half a century what students learn in second-year field work placements has been largely controlled by agency subsidies and fellowships weighted to the clinical elements in practice while the broader fields of social services, especially public welfare, do without second-year students. The flow of staff in these directions is thereby inhibited.

Is there not a problem of responsibility—perhaps even of ethics—in the use or implementation of findings from studies and research for which a great deal of private and federal money is given every year?

Even with the best studies, the temptation to shelve, or to hasty action, or to resort to the alibi, "Let us cure this one with more studies" equally must be resisted. In preparation for the *next* curriculum study, the journal looks forward to the report of the Commission on Practice and for collaborative investigation jointly undertaken by the CSWE and NASW of field work at all levels, for at least a five-year period. Meanwhile, is it too much to hope that an abridged paperback could be issued for those of us who cannot easily buy or house thirteen volumes?
—G.H.

[1] "The Curriculum Study" (13 vols.; New York: Council on Social Work Education, 1959).

[2] Ernest V. Hollis and Alice L. Taylor, *Social Work Education in the United States* (New York: Columbia University Press, 1951).

BY LYDIA RAPOPORT

The Concept of Prevention in Social Work

SOCIAL WORK IS experiencing a rapidly changing emphasis in professional practice. It seeks new knowledge and methodologies. The fluidity of the professional framework makes it especially accommodating to the absorption of new theory and constructs, and causes it to be particularly prone to global identifications with new models, which may or may not fit the abiding purposes and goals of the profession.[1] This problem is exemplified by the current high interest in the concept of prevention in social work practice. It is the thesis of this paper that the concept of prevention, borrowed largely from the public health model, is often used in a distorted and confusing manner in the social work framework.

PROBLEMS OF TERMINOLOGY

Interest in the concept of prevention has been given impetus by several distinct trends. One reason for enhanced interest is an outgrowth of changes within the social work profession itself, particularly in its evolving relationship to society as a whole. Wilensky and Lebeaux have called attention to the changing emphasis in social work from a "residual function" to an "institutional function."[2] When social work and social welfare are conceived of as a residual agency, they are seen as attending to temporary and emergency problems that arise when the regular and normal need-meeting social institutions break down and fail to provide adequately for basic human needs. In this residual role, social work is primarily concerned with amelioration and direct service methods to relieve stress and social breakdown.

From one point of view this conception represents a mechanistic concept of society and of social welfare, which might be compared to the mechanistic concept of disease. Here, the organism—society—is conceived of as a machine, and disease—social problems—is viewed as a breakdown in one of

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[1] This point of view has been stated masterfully by Charlotte Towle: "Among professions social work has had very little stability. It has been continuously in the making and remaking. It has never really had a chance to jell. Its orthodoxies have been relatively weak and its segmentation, as implied in specialization, short-lived. The tempo of its growth, always under necessitous circumstances, disposes it to ready identifications, both as a means to learning and as a defense. It is an avid consumer of nurture afforded. It is vulnerable to new integrations; herein lies its potential for growth or regression." In "Implications of Contemporary Human and Social Values for Selection of Social Work Students," *Social Service Review*, Vol. 33, No. 3 (September 1959), p. 264.

[2] H. L. Wilensky and C. N. Lebeaux, *Industrialization and Social Welfare* (New York: Russell Sage Foundation, 1955), pp. 98–99.

its constituent parts. Faulty parts are then mended or replaced.[3]

The newer conception views social welfare and social work services as regular, ongoing, and essential features of modern industrialized society, in which change in basic institutional patterns is rapid and ever present; welfare provisions and programs are seen as an essential component of modern life, transformed from temporary needs into basic rights. In this model, concern is not with faulty parts or conditions, but with the viability of human response and adaptation.[4] It would seem, then, that this newer concept of welfare as essential and ongoing, and therefore as a more growth-promoting type of institution, is particularly compatible with the philosophy and efforts of prevention.

This newer concept has been articulated in Werner Boehm's paper on the nature of social work.[5] In it he describes the functions of social work as follows:

1. *Restoration*—which consists of removal and control of factors which cause breakdown or impairment of social relationships. This function is essentially curative and rehabilitative.

2. *Provision of resources*—which is concerned with the creation, enrichment, and improvement of social resources. This function is essentially developmental and educational.

3. *Prevention*—which consists of early discovery, control, and elimination of conditions which *potentially* could hamper social functioning. It consists of (a) prevention of problems in the area of interaction between individuals and groups, and (b) prevention of social ills, through the study of "social infection" and "social contamination," and by the function of provision.

Another source of influence arises from our greater knowledge of the expanding field of public health, in which prevention figures as the key concept around which its functions are organized. Because prevention is a central organizing concept for the practice of public health, all its activities are subsumed under the umbrella concept of prevention. However, underneath the big umbrella the activities are strictly and variously defined according to different levels. A commonly accepted conceptualization of the levels of prevention in public health is in accordance with five gradients of activity, stretched along a continuum of what might be called the natural history of disease, including the prepathogenic period. The five levels are grouped as follows: (1) health promotion, (2) specific protection, (3) early diagnosis and treatment, (4) disability limitation, and (5) rehabilitation.[6]

Another frequent and more succinct way of grouping these activities has been in the order of primary, secondary, and tertiary prevention. These terms are heard increasingly in social work and will bear some elaboration.

1. *Primary prevention* includes measures undertaken to obviate the development of disease in susceptible populations. It consists of *health promotion,* which includes all measures and institutions that enhance the general well-being of a population. Primary prevention also encompasses the concept of *specific protection,* which implies some knowledge of causation and consists in the health field of such measures as immunization, sanitation, sound nutrition, and so forth.

[3] J. L. Halliday, "Principles of Aetiology," *British Journal of Medical Psychology,* Vol. 19, Parts III and IV (1943), pp. 367–380.

[4] Sir Geoffrey Vickers, in a paper on "What Sets the Goals of Public Health?" notes that with the introduction of the National Health Service in Great Britain a widespread, if half-conscious, view was held that a health service was a self-limiting service. In actuality, he maintains, the amount of effort that can be devoted to the health of individuals and the community increases indefinitely with scientific developments. *New England Journal of Medicine,* Vol. 258, No. 12 (March 1958), pp. 589–596.

[5] Werner W. Boehm, "The Nature of Social Work," *Social Work,* Vol. 3, No. 2 (April 1958), pp. 16–17.

[6] H. R. Leavell and E. G. Clark, *Preventive Medicine—for the Doctor and His Community* (New York: McGraw-Hill Book Co., 1958), Chap. 2.

2. *Secondary prevention* generally encompasses case-finding, diagnosis, and treatment. The emphasis is on *early* diagnosis and treatment. While treatment specifically attends to the relief of distress, as conceived in terms of secondary prevention it seeks to shorten duration, reduce symptoms, limit sequelae, and minimize contagion.

3. *Tertiary prevention* is largely concerned with chronic or irreversible illness; the goals are limitation of disability resulting from the illness and promotion of rehabilitation measures.

We see then that the total range of public health activity has been subsumed under three levels of prevention.

Social work has tended to embrace this model in an undiscriminating fashion, claiming that all social work activities are in the nature of prevention—or at least have preventive components. Such a claim can be made with any pretense at seriousness only if prevention is conceived of as a very relative term. We have already seen that in public health usage the term does reflect the whole of public health activities, but at the same time describes precisely the mediating and intervening steps that can be taken along the continuum of the natural history of disease, including the premorbid phase. In social work, the continuum may be along (1) a time dimension or (2) in accordance with the degree of pathological involvement. Thus we tend to call any intervention "prevention" if it is taken earlier rather than later (the philosophy of the "whole child" guidance movement rests on this view). Catching a disorder at the time of onset is considered prevention; if dealt with later it becomes treatment. This time dimension does not make for precision in theory or practice.

The other continuum is laid out on the axis of degree of pathology—*i.e.*, mild to serious. Intervention at a point of mild disturbance is considered prevention, insofar as the expectation is that a more serious or chronic state will be forestalled. In actuality, all these intervening activities occur *after* the existence of a defined problem—mild or serious, early or late—and therefore are examples of secondary or tertiary prevention.

We shall consider next the problem posed by the document, *Prevention and Treatment,* prepared by the NASW Commission on Practice, Subcommittee on Trends, Issues, and Priorities.[7] The issues are clearly presented, but the conclusions are ambivalent.

PROBLEMS OF DEFINITION

The statement affirms that we need clarity regarding the conceptualization of prevention in social work in order to stimulate and give impetus to preventive functions. It notes that "if prevention were regarded as inclusive of practically all social work practice functions and activities, the concept could easily become watered down and might well lose its *distinctive contribution* [italics supplied]."[8] The hope is that out of clarity will come new areas for exploration and emphasis in regard to their preventive possibilities. Hence clarity of definition is sought as a means of strengthening strategy. The search is for a concept of prevention likely to result in the greatest stimulus to a newer and effective practice.

This clear and affirmative position is abandoned as the statement struggles to gain recognition for the myriad social work interventions that are part of our broad treatment methods, by trying to make them part of prevention or to recognize in them a preventive component. All social work activities here are dedicated to the proposition that a condition must be kept from getting worse. The objective is sound, but why do such endeavors have to be dignified with the preventive label? In this instance, treatment and prevention become coterminous and we are right back where we started. Preventing an increase in severity or spread

[7] By Bertram M. Beck, based on the subcommittee's work, January 1959. (Mimeographed.)

[8] *Ibid.*, p. 9.

is more aptly called "control." This is a good and clear concept, but the NASW statement maintains regretfully that if the role of social work is the control of social problems, this leaves it without a preventive role.[9]

The statement then considers whether to narrow down the scope of prevention to apply to situations which are not now, but threaten to become, pathological. One is therefore dealing with potential rather than actual problems, or with pathology in its *earlier* stages. Here the statement hedges again: by combining potential problems with early pathology, primary prevention is made out to be coextensive with secondary prevention, which is concerned with case-finding and early treatment.

The final statement points to the fundamental ambivalence. The drafters of the document, we are told, discarded the possibility of defining prevention in a restricted sense as meaning "keeping something from happening."[10] The reason for this astonishing conclusion is that practically all social work activities are launched after a problem is manifest. The logic embedded in this decision is questionable: since the narrow definition of prevention excludes most of present social work, it is proposed that we discard the narrow definition and label what we are now traditionally doing as "prevention." The implications are worrisome indeed; they directly negate the earlier stated purpose to find a definition that will give the greatest impetus to newer modes of approach. The discarded definition is the most likely to yield fresh and creative social work activities.

From the above discussion the question arises as to whether there is any validity in altering social work language in order to dignify our traditional efforts with a more popular term. This is mere sophistry and turns a word into a slogan. What we are doing is to take the word "prevention" out of the more precise public health context and apply it to the social work field, whose rationale, objectives, and methodologies cannot all be neatly squeezed into a single organizing concept. To strive to apply a unitary organizing concept to a field that operates by many others—and in any case has not reached consensus or stability as to what this concept shall be—only creates confusion, leads to unsubstantiated claims and professional self-deception, and fails to further our purposes either scientifically or professionally.

The struggle to encompass the concept of prevention is reminiscent of the profession's struggle to define rehabilitation. There we vacillated from defining rehabilitation as a point of view, or approach, to the narrower conception of a specific type of endeavor conducted in a medical facility concerned with restoration of physical and social functioning. The controversy has largely abated. In general, there is merit in defining an area of practice more narrowly in order to improve professional practice.

PROBLEMS OF "MYTHOLOGY"

The next group of problems to be discussed deal with implicit value assumptions. Some approach the order of myths and serve as determinants as to what position we take.

One view of the concept and objectives of prevention is embedded in an ideal value assumption which elevates prevention to the top of any hierarchy in a continuum of health and welfare activities. Thus the assertion is made that prevention of the development and spread of social pathology is better than amelioration, cure,[11] or rehabilitation of such ills. If this means that

[9] *Ibid.*, p. 12.

[10] *Ibid.*, p. 9.

[11] The notion of cure in the realm of social pathology and even in defined psychiatric illness is itself a fiction, since it contains the idea of an absolute state of health; the archaic term for "cure" is "heal," which—despite its religious or mystical aura—is closer to our purposes. This implies restoration to soundness, which is more compatible with current ideas of restoration of functioning. Similarly, Dr. Mary Sarvis suggests that psychotherapies are largely based on the surgical model of excision instead of being flexibly based on the "useful next step."

the possibility of sparing people suffering, distress, or unwholesome experiences is a worthy objective, then the value position is an incontrovertible one from any humanitarian or professional standpoint. If, however, it means that applying measures to relieve any one given individual from distress or destructive experience is less worthy than the application of broad social measures to relieve suffering in general—then, for social work, this is an indefensible position. For deeply in the core of the social work profession's value base rests the assumption that the highest good is the protection and preservation of the essential worth, dignity, and integrity of each and any human being. This essential value is more central to our profession than any other, and has led social work to give at least equal if not more attention to the psychological meaning and human impact of the helping process itself, rather than to development of helping techniques alone.

Another myth is the notion that the task of working at the preventive level is easier, less frustrating, and more rewarding as to results than trying to intervene at the level of manifest and well-developed pathology, which may be highly complex, entrenched, and even irreversibly chronic. There is little evidence to warrant such a belief. In the realm of social pathology the problems of definition and intervention are equally complex, given the present state of our knowledge, regardless of the level of prevention. Moreover, we are not yet in a position to assert which level of activities yields the greatest gains in terms of effectiveness. As a matter of fact, some hold the opinion that, since prevention in social work is a new, untried, and fuzzy area, we at least have greater certainty of results—even within familiar limitations of resources, skills, size of population reached, and so forth—with known methods of treatment and rehabilitation.

The NASW statement raises the question of the relationship of prevention to social change. The statement expresses the concern that if social work were to move toward heavier emphasis on prevention, "the profession might lose sight of its major role as an inducer of social change." [12] The reasoning behind this remarkable concern seems to be as follows: positive changes in society often induce social problems as a result of a process of social change. Social work does not wish to reduce social change in order to reduce social problems. Moreover, it recognizes that problems of disordered individuals and groups may arise in part from a discord between them and social norms. Social work therefore has a role in inducing social change in order to deal with unhealthy social norms. Prevention in social work is seen as being directed to social change and to individuals and groups whose problems are induced by social change and by conflict with social norms.

All this is quite reasonable and in keeping with professional objectives and commitments. However, the following question is then addressed to the membership in the statement of issues: "Can social work prevent problems from arising and still escape the role of being an instrument to induce conformity?" [13] It is not clear how this concluding question evolved out of the foregoing considerations. The goals of prevention and the goals of social change appear somehow made out to be antithetical rather than identical. Perhaps there is an implicit assumption that one can prevent only if one can hold static the variable of social change, which in itself continually produces the germs of new disorders and problems. The statement fails to recognize that preventive activities themselves are generally vehicles for social change.

The above confusing position may be grounded in the initial pronouncement of the NASW statement, which affirms that "social work interest in prevention arises out of the profession's service commitment." [14] This position might be ques-

[12] *Op. cit.*, p. 2.
[13] *Ibid.*, p. 4.
[14] *Ibid.*, p. 1.

tioned. Furthermore, this major premise may be the cause of some of the above confusions and casuistries. The social work interest in prevention should arise out of the profession's commitment to social change, which the statement has already affirmed to be one of its major roles! If this were declared as the central position, the rest would flow logically and naturally, without any artificial dualism. Moreover, such a position would lead us to explore and concentrate more vigorously on primary prevention as a means of social change, rather than manipulating and stretching concepts of secondary and tertiary prevention which more clearly express the service and ameliorative functions.

One other myth that generates opposing viewpoints should be examined. This is the myth of causation. It is generally posed in the following terms: in order to prevent the onset or spread of a disorder, it is necessary to know the specific factors of causation. This is offered as an argument particularly in the realm of mental illness and in social pathology. Since there is lack of agreement and uncertainty as to specific cause, and increasing recognition of the multicausal nature of these problems, there tends to be a feeling of helplessness or discouragement, if not outright indifference, to the possibilities of prevention. Sometimes, too, the discouragement is managed more distantly by hiding behind the assertion that we need much more research and specific knowledge before we can do anything.

This position is easy to recognize but less than sound from several points of view. In social work we shall always operate with less than full and certain knowledge.[15] This is one of our built-in professional stresses.[16] Because of the mandate given to us by society and because of the nature of our social commitment, we cannot afford to wait. This is another value position that binds us.

A more cogent argument, however, lies in the nature of the fallacy itself. René Dubos presents the case most lucidly.[17] He points out that modern medicine is wedded to the "doctrine of specific etiology," adopted from the field of infectious diseases and the germ theory of disease from which the bulk of modern medical achievements stem. Until late in the nineteenth century, disease had been regarded as resulting from a lack of harmony between the sick person and his environment. Dr. Dubos points out that the doctrine of specific etiology appeared to negate this philosophical view of health as equilibrium. It did, however, save medicine from a morass of loose words and vague concepts. The theory held that each disease had a well-defined cause and that its control could best be achieved by attacking the causative agent or focusing treatment on the affected part of the body. Dr. Dubos maintains that the present generation actually believes that the control of infectious diseases can be credited to the widespread use of antibacterial drugs. Actually, the mortality of many other infectious diseases began to recede long before the discovery of specific treatment—indeed, before discovery of the germ theory of disease. He credits actual control to the campaigns of humanitarian movements which were dedicated to eradicating the social evils of the industrial revolution and to the restoration of harmony in life with the ways of

[15] A similar position is taken by Dr. B. Pasamanick, a public health psychiatrist, who says, ". . . a considerable amount of prevention and control of mental disorders has occurred, and it would be possible to do prodigiously more in the immediate future without any accumulation of new knowledge of etiology or treatment, provided we are willing to pay the costs in terms of money and social effort." He elaborates further, "The experimental testing of prevention and control measures may very well open new paths of etiology, and in chronic disorders it frequently the only method for obtaining definitive evidence of causation." From "Prevention and Control of Chronic Disease," *Journal of Public Health*, Vol. 49, No. 9 (September 1959), p. 1129.

[16] L. Rapoport, "In Defense of Social Work: An Analysis of Stress in the Profession," *Social Service Review*, Vol. 34, No. 1 (March 1960).

[17] *The Mirage of Health*, World Perspectives (New York: Harper & Brothers, 1959).

nature. He concludes that it is a remarkable fact that the greatest strides in health improvement were achieved in the field of diseases that responded to social and economic reforms after industrialization.

The implications of this line of thought are so important that they bear restatement by quoting directly from the essay:

> The ancient concept of disharmony between the sick person and his environment seems very primitive and obscure indeed when compared with the precise terminology and explanation of modern medical science.
>
> Unquestionably the doctrine of specific etiology has been the most constructive force in medical research for almost a century and the theoretical and practical achievements to which it has led constitute the bulk of modern medicine. Yet few are the cases in which it has provided a complete account of the causation of disease. Despite frantic efforts, the causes of cancer, of arteriosclerosis, of mental disorders, and of the other great medical problems of our times remain undiscovered. It is generally assumed . . . that the cause of all diseases can and will be found in due time—by bringing the big guns of science to bear on the problems. In reality, however, search for *the* cause may be a hopeless pursuit because most disease states are the indirect outcome of a constellation of circumstances rather than the direct result of single determinant factors.
>
> . . . there are many cases in which a given disease can be controlled by several unrelated procedures.[18]

IMPLICATIONS FOR PRACTICE

The implications are profound in their direct relevance to prevention in social work practice. They suggest strongly that the preoccupation with tracking down a causative agent is far from fruitful or even necessary when dealing with a multifactorial system. It is more useful, therefore, to understand the interrelated parts of a complex system and to plan strategy which could interrupt, at any one of several points, factors contributing to the development of pathology. Classification of cause into predisposing, precipitating, and perpetuating cause is also useful.

Let us return now to a further examination of some key operating concepts from the field of public health to see how they might be applied in the context of social and emotional health.

1. The major mode of inquiry for public health is the epidemiological method, which studies the incidence and prevalence of a disease and the related factors that seem to be associated with it in a defined population. The use of this method is only in its infancy in the area of mental illness and social pathology, but despite methodological difficulties promises to be very useful as a guide to preventive action.

2. Prevention in public health is directed at the community or a given population and not at specific individuals. Moreover, the population designated for a preventive program is usually a specially selected one, deemed particularly vulnerable to certain hazards, and is thus sometimes designated as "a population at risk."

3. Prevention is carried out via three major types of intervention: (a) removal of the etiological agent; (b) removal of, or altering, one or more important associated factors; and (c) strengthening populations (individuals) against the noxious agent, or related factors. Translated into social-psychological language, this means: (a) removing or diminishing specific stress; (b) reducing the secondary effects of stress; and (c) strengthening the maturational processes and adaptive mechanisms in a population. If these activities are carried out prior to the onset of defined pathology, they are in the nature of primary prevention.[19]

With these concepts in mind, let us examine now where along the continuum of public health prevention we can place social

[18] *Ibid.*, pp. 86–87.

[19] Suggested by unpublished comments of Dr. Leonard J. Duhl, who is with the National Institute of Mental Health.

work functions, and what activities in social work practice might readily and profitably be developed in order to enlarge the preventive role. Social work has long been concerned with (1) removal of the stress of deprivation, (2) alleviation of the effects of stress, and (3) strengthening of individuals, achieved through the provision of basic needs and the strengthening of ego-adaptive mechanisms. In general, however, the population for which social work plans its programs and services is one already designated as pathological. Using again the framework developed by Drs. Leavell and Clark, we might say that the bulk of social work activity falls therefore into the category of secondary and tertiary prevention. In Werner Boehm's terminology, this area is covered by the concepts of restoration and, in part, provision. All these measures are relevant to the effort of control of the extent, severity, and spread of social problems. It was suggested earlier that primary prevention—*i.e.*, "keeping something from happening," which was unfortunately discarded by the NASW statement as an operationally useful definition—might, in fact, be the most challenging and creative area in which social work wisdom could be employed and a "distinctive contribution" made. Prevention in its archaic usage meant "to anticipate." Efforts at primary prevention in the realm of social problems is largely in the nature of "presumptive prevention." Nonetheless, our presumptions rest on considerable research and on cumulative empirical wisdom. What, then, are the opportunities for social work in primary prevention?

PRIMARY PREVENTION IN SOCIAL WORK

The first phase of primary prevention is health promotion or, more broadly, promotion of well-being. The whole of society and all its growth-promoting social institutions play a key role here. The family, the field of education, church, organized recreation, and so on, are highly relevant. The chief responsibility of social work does not lie in the area of promotion of well-being, although many social workers are directly involved in growth-promoting activities and institutions. An important role of social work, however, might be that of "watchdog": to be alert to weaknesses or failures in the growth-promoting type of agency—to point them out, and suggest modifications in both specific program and institutional arrangements which may, by their existing nature, defeat the stated objectives. Social work has not been sufficiently articulate in this area. We are beginning, however, to develop interest in, and more specific knowledge about, the impact of institutional arrangements and culture on personality development.

Social work could also be instrumental in encouraging the health- and welfare-promoting agencies to develop programs which would strengthen individuals in dealing with specific life tasks. Efforts could be directed at maturational processes and adaptive mechanisms. This is sometimes referred to as "emotional immunization," which—analogous to physical immunization—can be passively or actively acquired. Passive immunization in mental health is acquired through the elimination, or more realistically the reduction, of stress. Active immunity can be promoted by strengthening people in methods of problem-solving through information, training, and experience as a way of preparation for dealing with unanticipated crises, as well as crises of maturational steps and role transition. For example, family life education could be directed more sharply at younger, less emotionally competent groups as preparation for husband-wife roles and later parent roles, including preparation for parental tasks and expectation of child development and nurture. Some of this, called "anticipatory guidance," is being done increasingly with individuals who make use of the secondary prevention type of program. It should also be done with populations not

yet manifesting problems, which can be predicted as likely to develop difficulties.[20]

The second phase of primary prevention, that of specific protection, is a most challenging area in which to apply social work knowledge and skills. Several different types of activity come to mind. One is the social work function of provision, which Werner Boehm rightly considers as having a role in prevention and which could be classified in the second step of primary prevention, that of specific protection. Thus the intent of the social security program is to offer specific protection to a population at large against the stress of basic deprivations through income loss.

Another example is that of Dr. John Bowlby's studies of the effects of prolonged and early maternal separation and maternal deprivation. These studies yield data and guides for action toward specific protection. All measures that would reduce the incidence of maternal separation would be a form of specific protection. The absence of a continuing and satisfactory mothering relationship is presumed, on fairly good evidence, to lead to the development of psychopathology, and repeated and prolonged separations are presumed to lead specifically toward the development of psychopathy—what Dr. Bowlby used to call the "affectionless character." The measures already taken along the lines of specific protection are increased parental visiting in pediatric hospitals, increased home treatment, homemakers at time of crisis to keep children from being placed, modification of adoption laws and procedures to facilitate earlier adoption, and so forth. Social work contributes to change in this area through the active use of existing services and by recommending administrative and legal modifications.

Still another approach is exemplified in a pediatric hospital project.[21] This program is designed to protect children from the effects of separation, isolation, and specific reaction to medical and surgical procedures. The method used is that of social group work and consists of guided group experiences, catharsis through verbalization and play, and the opportunity for mastery of traumatic events as well as growth-oriented experiences. Intervention here is beamed at a particularly vulnerable population, *i.e.*, groups of children in the hospital. It is directed at lowering the hazards encountered in a hospital by provision of a direct service to groups of children and by influencing ward management and procedures (the institution) in order to strengthen the children's adaptive and growth potential.

Much more could be done in the area of specific protection by way of reducing the secondary effects of stress, in this instance the stress of separation for the young child. For example, we might become more alert to the remarkable increase in the number of working mothers of young children for whom continued and adequate nurture is required, not only at family crisis points, but as a style of life in which separation and substitute mothering become a daily reality. We have done very little to provide adequate day care services as part of public social policy, and even less to build into day care programs all the mental health safeguards and services with which we are already familiar and which we could offer as methods of specific protection.

There is another role for social work which needs urgent expansion, viz., the reevaluation and reorganization of health and welfare services with some of the following objectives:

1. To help people get needed service at the time of acute need with a minimum of the administrative obstacles that tend to eliminate all but the most highly motivated or most chronically dependent. For example, the ever lengthening waiting lists of

[20] *See* a challenging paper by Jessie Bernard, "Neomarital Programs," in which she uses the concept of "anticipatory socialization." *The Social Welfare Forum, 1958* (New York: Columbia University Press, 1958), pp. 239–255.

[21] At Boston City Hospital, under the social work direction of Marion Chuan.

child guidance clinics, and now increasingly of family agencies, make a mockery of the need for early and prompt treatment (secondary prevention). One may question the necessity of formal and lengthy diagnostic studies on a routine basis which may or may not be of real consequence to a family, and which often fail to be shared in a vital fashion with appropriate caretakers who could conceivably, with consultation, be of assistance to the family.

2. To insure that services are offered in a manner which does not tend to fragment the individual or the family, but takes into its purview the total person and family need. For example, in settings where social work is an auxiliary service it becomes particularly important to bring this point of view to other professions. In such settings, social work serves to reduce fragmentation by co-ordinating resources with need.

3. To guard against legal structure and administrative usage which, in actuality if not by intent, undermine and impair the independent striving of individuals and put a premium on regressive and passive tendencies. For example, one might question whether the regulations and administration of certain social security programs do in fact enhance independent functioning or whether they unwittingly reinforce dependency. There is evidence that some of the built-in strictures of the medical disability program and the Aid to Dependent Children program tend to undermine certain healthy strivings and reinforce certain forms of personal and family disorganization.[22]

In summary, the point of view here urged is that social work has major responsibility for amelioration and control, and a vital role in all levels of prevention. Prevention should be more strictly defined to sharpen professional practice and give impetus to greater activity in the area of primary prevention, which involves the imaginative application of all social work methods in anticipating problems and needs.

[22] For further elucidation of this problem see Alvin L. Schorr, "Problems in the ADC Program," *Social Work*, Vol. 5, No. 2 (April 1960).

BY ALASTAIR MACLEOD AND PHYLLIS POLAND

The Well-Being Clinic

THE DEPARTMENT OF Psychiatry of McGill University in Montreal has in the past six years initiated a mental health activity called the Well-Being Clinic. This was an experiment in providing a public health service related to mental rather than physical health. Original goals were: to offer the ordinary citizen a routine, periodic check-up for his mental health, just as earlier-established "well-baby" and "well-woman" clinics offer routine physical health check-ups. The clinic, which is under psychiatric consultation, is staffed by members of the social service department of the Allan Memorial Institute[1] and by "Counsellors Associated," a group of Montreal social workers in private practice.

The purpose of the interview is to determine how well the individual is facing up to and coping with his everyday problems, rather than finding out what problems exist. He is asked, and helped, to review his functioning in each major area of his lifework, family and marital relationships, friends, recreation, community activities, and physical health. His goals are discussed with him and he is asked what he is doing to achieve them. If he recognizes his problems and shows evidence of working toward a solution, and if his goals are realistic and within his capabilities, he is rated essentially healthy and is told so by the counselor. Some clients have problems of personal and social adjustment that are temporarily beyond their ability to handle effectively. The clinic does not offer treatment but refers such cases to the appropriate agency or service for further evaluation and help. A small percentage of our clients—about 9 percent—are found to be chronically impaired but appear to be functioning to the maximum of their ability. In these cases the clinic serves as a source of referral if they should break down in the future.

The clinic originated in 1954. At that time a "well-being" assessment was offered to all those registered for the "health and charm" course given by the Montreal YWCA. This course consists of a series of ten lectures concerned with physical and emotional health, and with social skills in everyday living. The latter include such topics as good grooming, how to entertain, and art and music appreciation. The well-being interviews are given during the course, the appointments being made at the end of the first few lectures. Registration now amounts to about 100 women a year, and nearly all ask for well-being appointments. Ages of the women range from 18 to 70 years, with the majority in their twenties and thirties. They include office workers, business people, housewives, and professionals. The interviewers receive a fee, which is included in the fee for the total course.

Later, the clinic was included in a similar course offered by McGill University Extension Department (night classes). This course, entitled "Understanding Ourselves," consists of a series of lectures on mental health given by staff of the McGill Depart-

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[1] The Allan Memorial Institute is the psychiatric department of the Royal Victoria (General) Hospital, and the research and teaching institute of McGill University.

ment of Psychiatry, and is followed in the second term by discussion groups led by psychiatrists and social workers. Well-being interviews are offered on the same basis as in the YWCA health and charm course. Registrants include men and women, but the majority are women.

To date some 600 clients have been seen in the clinic. It has now become possible to make a number of advances in the assessment of past work and in exploration of the most fruitful directions of future development. One of these new activities has been a survey of earlier clients to get a retrospective estimate of the value of their initial mental health check-ups. Others have been the application of the check-up idea in the educational and business fields. Out of these activities have arisen certain hypothetical considerations, and this paper deals with these activities and speculative considerations.

SURVEY OF EARLIER CLIENTS

In 1956 the first 100 cases seen at the YWCA were studied and classified in three broad categories:

1. The essentially healthy
2. The relatively healthy who are handicapped to some extent by personal or social problems
3. The seriously impaired

In 1959, for purposes of comparison, another sample of 100 cases seen at the YWCA after 1956 was similarly studied and classified; the results of the two studies are compared in the following tabulation:

Health Status of Presenting Clients

	1956	1959
	%	%
Category I (essentially healthy)	48	56
Category II (relatively healthy)	36	34
Category III (impaired)	10	8
Unclassified	6	2

The comparison suggests that if the mental health status of clinic clients is any indication, the Montreal mental health picture in this group has remained more or less constant since the clinic was first opened.

Among the 100 cases in the later sample, a total of 31 referrals were made as follows: 6 to private psychiatrists, 9 to psychiatric clinics, 2 to physicians, and 14 to social agencies. This compares with a total of 55 recommended referrals in the first 100 cases. In both studies, all were women.

As an experiment, another evaluation was made by means of telephone interviews. The object was to ask clients how well they had been doing since they had their mental health check-up and to elicit their current opinions as to the value of the check-up. A group of 100 persons who had had well-being interviews at the YWCA between six and twenty-four months earlier were selected, and the interviewing was done by seven counselors who had either conducted the original interviews themselves or had a full record of them. The counselors were asked to record their assessment of the clients' reactions to the telephone conversations. Clients were not specifically queried about their reactions to the calls, but the general tone and changes in tone, inflection, and tempo were noted.

Of the 100 cases chosen, 55 were reached by phone. Of these, 28 definitely believed they had benefited by their check-up, and from the statements made by the clients and the tenor of the conversation the counselor came to the same conclusion. Another 23 were judged to be maintaining about the same level of mental health, and 4 seemed worse.

Among those in whom improvement was most marked was Miss S. At the initial interview she had reported that she disliked her job, was too tired to go out in the evening, had lost contact with most of her friends, and felt depressed. The clinic suggested she see a psychiatrist. One year later over the telephone she sounded cheerful, said everything was fine now. She had been promoted at work, was going out a lot, even had a boy friend! She had not acted on the

suggestion that she see a psychiatrist because she began to feel better shortly after the interview.

Most of those reporting improvement gave nonspecific reasons for feeling better. "It is good to get things off your chest." "It helped me to take a different look at myself." "I came away feeling good." "It made me realize the need for social contacts." A few were more specific: "I was all mixed up and it helped me to get things straight so that I was able to do something about the things that were bothering me." One girl, a newcomer to Montreal at the time of the check-up, recalled that she had been lonely and had despaired of ever being able to make new friends. Talking to the interviewer, she said, had given her the self-confidence to start tackling her problems.

In one case the client was definitely in a poorer frame of mind than when first interviewed, but attributed this to the fact that she had recently undergone an operation and had been bereaved by the death of a close relative. In the three other cases judged to have lost ground since the original check-up, none had acted on the referral suggestions made in the original interview.

Of the 55 individuals reached by telephone, 30 were friendly from the very beginning of the conversation. Another 6 were neutral or hostile at first but became friendly when they realized who was calling and why. Of the remainder, 10 were neutral in attitude throughout and 6 were hostile. Interviewers did not record reactions in 3 cases.

A mailed questionnaire in this field usually brings about 25 to 30 percent returns. In this instance, the telephone survey doubled this percentage. In addition, the telephone provided a much broader range of information than could be obtained through a mailed questionnaire. The give-and-take of telephone conversation more nearly approached face-to-face conversation in meaningful communication.

A disadvantage of the telephone method noted by the interviewers was lack of privacy for the clients. Often other people in the home or office were able to overhear the interview. None of the clients had expected the call, and it is believed that if they had been told during the well-being interview that there would be a telephone follow-up, the calls would have received an even higher percentage of friendly receptions. This speculation will be tested in future clinic procedures.

One further finding may be only indirectly related to the use of the telephone. Interviewers found they obtained fuller and more specific information from their "own" clients than from those of other interviewers, although they had studied the records carefully before telephoning. When there had been no previous face-to-face contact, the nonverbal aspects of the telephone communication were more difficult to interpret.

OTHER USES

In educational field. The Provincial Association of Protestant Teachers asked a Well-Being Clinic staff member to contribute an article for their professional journal explaining the function of the clinic and describing its services. As a result, a number of teachers have had well-being interviews, and in one instance an entire school staff, including the principal, came for check-ups. What they found of particular importance was that the mental health assessments are entirely voluntary, private, and completely confidential.

At the university level, postgraduate students in their final year at McGill's School of Social Work were given the opportunity of a Well-Being Clinic interview as part of their course on psychiatric information. The interviews were offered as a supplemental university health service. To protect confidentiality and insure freedom in the interview, students were advised to make their appointments directly with the clinic rather than through the school, and

were assured that no information discussed in the interviews would be made available to the school. The value of this service is perhaps best indicated by the fact that the students themselves recommended to the school that, in future, well-being assessments be made available to first-year students, with a follow-up interview in the second year.

Comments by students in class discussion of the service can be summarized briefly. The interviews, they said, had increased their respect for the profession. Previously they would not have considered going to another social worker for help, but they would do so in future. Moreover, they had felt free to discuss many problems and worries they would not have discussed with faculty advisers for fear of prejudicing their scholastic standing and future job prospects. From an educational point of view, the interviews had given them the opportunity to observe skilled interviewing, providing a standard against which to measure their own interviewing techniques.

Individual comments by students included:

"I was unsure about choosing social work. Now I feel less tense and clearer about my future plans."

"I talked about things I had not thought of for years. I think I've got things sorted out better now."

The interviewers reported that two of the students themselves had grave doubts about their abilities and their suitability for social work. Both had tried to cover up feelings of inadequacy and feared these feelings would be revealed. Two other students had serious family problems which they were "putting off" until after graduation. On the advice of their counselors, both have since accepted referral for psychiatric help.

While these sorties into the educational field are as yet too recent and modestly scaled to permit an evaluation, their findings are nonetheless both provocative and promising. The individual who has a loosely delineated image of himself functions less effectively than the person with a clearer appreciation of himself, his roles and relationships, and the value of his work and his goals. Such a clearer self-picture comes through transactions with others. These transactions provide confirmatory evidence of the worth of self and one's work; they counteract the "deprecatory doubt" which so frequently assails youth.

None of the students interviewed had ever before had the opportunity to sit down with a counselor to examine his role in life. Almost all reported an increased sense of well-being following the opportunity to discuss and assess themselves.

The students were also given some training in the techniques of conducting well-being interviews. Following their personal experience of being interviewed by a skilled clinic interviewer, they were expected in turn to conduct a well-being interview and to assess the mental health status of a relative of a patient undergoing psychiatric treatment at the Allan Memorial Institute.

In industry. Industry has long been concerned with the problem of "incidental sickness" absenteeism—repeated absences of short duration because of relatively minor physical illnesses requiring little or no treatment. How important are emotional and social factors in the etiology of this form of absenteeism? In seeking the answer to this question, a large business organization collaborated with us by setting up a model well-being clinic attached to its own medical department.

After the establishment of the clinic, a group of women employees in the accounting department who had complaints for which no adequate physical cause was discovered were offered a diagnostic appointment with the psychiatrist to rule out mental illness, and a well-being interview was given by the social worker attached to the project. The majority of the women in the group were between 16 and 25 years of age, and two were in their thirties. Most were single and came from lower-middle-class backgrounds. All were clerks and typists. A total of 39 employees were interviewed,

and each one gave permission for the findings to be discussed with their supervisors. Most of them also accepted a reassessment about three months later, and the individual supervisors were interviewed four to eight months later.

Reasons given for their rather frequent absences included "stomach upsets," headaches, "flu," menstrual cramps, and colds. During the well-being interview, problems disclosed included social isolation, family difficulties, boyfriend troubles, marital problems, and adolescent problems of maturation.

The follow-up report of the supervisors revealed that 24 out of 39 improved in regard to attendance, punctuality, and productivity. Of the remaining 15, there was no change in 7, one was worse, and no report was obtained from 7, either because they had left the company or because the supervisors had changed.

Objective comments of supervisors reporting improvement included: "No further absences," or "Absence rate now acceptable." "Output of work increased." "Promoted." Some further impressions were: "More cheerful and friendly." "Has more pep." "Appears happier." The improvement, according to the supervisors, had been sustained since the initial well-being interview which had taken place some four to eight months earlier.

In all but one case, the interviewer's assessment in the follow-up interview agreed broadly with that of the supervisor. In the one case of disagreement, the employee had made positive changes in her environment and appeared much more stable and contented, but the supervisor stated there was "no change," although all evidence was to the contrary. In all other cases where supervisors reported "no change" or "worse," the interviewer had predicted at the time of the initial interview that the outlook for improvement was unfavorable.

The life situations and problems of this group were typical of those encountered in the community at large. The following are examples:

Miss W, aged 22, came to Montreal a year previously from a small isolated town. One of a large family, she had known most of the people in her home town, and had taken part in sports and community social activities. In Montreal, she lived alone in a room, had little recreation and no friends, even among her fellow employees. She was frequently absent due to "stomach upsets" associated with menstruation. Her problem did not appear to be an inability to relate to people as much as a lack of experience and skill in converting casual contacts into friendships. She readily accepted referral to the caseworker at the YWCA, who in turn introduced her to individuals and groups there. Four months later her supervisor reported no further absences and said she appeared more cheerful and friendly with the staff.

Miss P, aged 18, complained of headaches. Her work problems included frequent absences, lateness, and "high error rating." Her chief complaint was that at home she was treated like a child. Her father did not want her to have boyfriends and she had to be home by 10:30 even on weekends. It was suggested to her that a girl capable of earning her living should have more freedom. She was advised, however, to assert her independence gradually in a way that would not be too upsetting to the family. During the interview she decided to make a start by persuading her parents to allow her to keep her own pay check and pay them a reasonable amount of board money. A follow-up two months later showed that she had carried out this plan and that the family had also become more permissive in regard to dating. The supervisor later reported greatly improved attendance and punctuality, and said, "Her record is excellent, and she is now above average in productivity."

Miss S had been deserted by her mother when she was 3 years old. She had known for some time that her mother was ill in

a hospital for incurables in another city. The young woman was torn between pity and hostility toward the mother who had deserted her. During the interview she admitted she would feel guilty for the rest of her life if she did not visit her mother, and decided on the spot to go over on the next long weekend holiday. Her supervisor later reported improved attendance and punctuality, and fewer complaints of fatigue, colds, and dysmenorrhea.

LINES OF EXPLORATION

Health is not a negative concept. It is more than the absence of disease—rather a dynamic measure of an individual's ability to function effectively despite biological, psychological, and social handicaps. Viewed in this light, the term "therapy" need not be applied solely to the treatment of illness; it can as properly be applied to any procedure that improves the health of the healthy.

Health is a function of human behavior. And human behavior can be regarded as the resultant of an interplay of forces operating at biological, psychological, and social levels. The resolution of conflicting forces in any of these areas can result in an overall improvement in functioning—that is, improvement in health. In many cases, disturbances at the biological and psychological levels are of primary etiological importance and require medical and psychiatric treatment. But in many other cases, it can be argued from findings of the Well-Being Clinic, the significant etiological factors are mainly social. For example, nearly all the clients who improved following their Well-Being Clinic interviews had been suffering from some degree of social isolation.

Judging from the eagerness with which these people seized upon the opportunity of a clinic interview, and from their subsequent improvement, there would seem to be a considerable hunger in the community for the type of meaningful, self-revealing, face-to-face transaction provided by clinic interviews. One promising line of exploration is the use of the clinic as an instrument to detect and measure the amount and forms of social isolation in the community and to assess the effectiveness of any procedures designed to overcome this threat to health.

Another line of exploration will concern itself with the problem of making the clinic immediately available to clients at times of personal crisis when counseling is known to be most fruitful. In this regard the usefulness of the telephone as a medium of contact will be further investigated.

The Well-Being Clinic, which began as an experiment in providing routine mental health check-ups with no therapeutic objective, is proving to have some therapeutic impact on its clients. This unanticipated effect is stimulating speculation as to the possibility of extending the usefulness of the clinic in the development of new procedures in the field of community mental health.

BY MILTON WITTMAN

Preventive Social Work: A Goal for Practice and Education

OF ALL THE helping professions, social work has the most to gain from the development of a truly workable preventive function. The difficult questions arising from the need to staff existing services, from the demographic trends which point to even greater needs for services, and from the apparently insoluble nature of the basic social problems we deal with, require our close attention. It is not necessary to review the statistics that tell of the volume of social impairment in this country. These are well known to the average social worker, since they are in daily evidence in the case load and working responsibilities of the practitioner, whether his field is casework, group work, or community organization. It will be the contention of this paper that the need to develop a conception of *preventive social work* has not yet been squarely faced by the profession, and that we are losing an opportunity to apply a better proportion of our professional effort and energy to aspects of social problems which now receive minimal attention and concern. The approach here will be to discuss the general concept of prevention as now known and to review some of the present applications in other fields. We shall then look at the status of prevention in the field of social work and try to state the implications for social work education and practice. That there are many must be apparent to all of us.

Prevention is itself an exciting word. It creates in the mind of the professional person an ideal of some unknown but effective resource or method which, if properly identified and used, will dissolve an existing social dysfunction into tangible social usefulness. This image must be particularly disturbing to the heavily burdened social worker who is faced with the conclusion that there is no end to the growing case load. For every case closed, two new ones are opened; and the closed cases have an exasperating way of refusing to stay closed. While this may seem to refer only to case-serving agencies, it is true in all parts of the field. The hope that total needs for social treatment can be met is far from realization under our present-day structure of services.

As we look at some of the older helping professions, we find that the function of prevention has for long assumed major proportions. One may cite the fields of preventive medicine and what is known as preventive psychiatry. Beginning with the need of the human organism to be protected from its environment, the field of public health has extended its boundaries to include greater concern for the social and emotional factors in health. As stated by a leading source on preventive medicine:

> Behind every condition of health or disease is the phenomenon of continuous alteration. These are not fixed states but continuing processes: a battle on the part of man to maintain a positive balance

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against the biologic, physical, mental, and social forces tending to disturb his health equilibrium.[1]

Thus environment is construed as referring to the total of life forces exerting an impact on the individual in his social situation. The social and emotional factors in human adjustment to the environment are now commonly accepted as a major concern of the practitioner of preventive medicine and public health. The science of the preservation of health as related to physical causation is far ahead of the knowledge we possess of relevant psychosocial factors. Yet, as noted by Scheele,

> Of all the medical and social aims in the field of chronic disease, prevention is probably the most difficult of achievement. At the present time, the body of scientific knowledge on prevention is smaller than on any other aspect of chronic disease except etiology.[2]

With the new developments of the years since World War II, which have seen an increase in the applications of epidemiology and human ecology to mental health,[3] there has been correspondingly greater interest in the evolution of workable preventive methods which will improve and preserve health in the general population.

Another aspect of prevention which has had much attention of late is the notion of "preventive intervention." This has been developed by Lindemann and his colleagues. It postulates the identification of *crisis* in family life as the point at which professional help can *intervene* to prevent breakdown. By designating certain *caretaker* groups and their respective roles in the system of community services, Lindemann lays the basis for a prototype of consultation service, as backstop to other services, which can attune the practicing professional to the mental health considerations in his practice. The conviction is clearly stated that mental health (preventive) work involves an amalgam of skills and knowledge "not at present possessed by any one profession."[4] It is important to note that here a unique agency structure is developed to maintain surveillance over a community with an eye to mental health hazards. Individual and group consultation is provided for "caretaking" agencies and professions around emerging problems which may affect the social well-being of the people being served.

The trend in medicine and public health to examine the social environment of family and community in quest of a rationale for prevention is met by a reciprocal move from the social sciences. A kinship of interests is causing sociology, cultural anthropology, and social psychology, in particular, to produce some highly significant new research and applications of new knowledge. While no obvious solutions to the long-standing problems of psychopathology and social dysfunction have been found, the field of public health has gained from this cross-fertilization.

FRAMEWORK FOR PREVENTION

The accepted structure for a medical or social service rests upon the conceptual formulations involved in the cycle of diagnosis and treatment. In basic professional practice, the physician and the social worker are first concerned with assembling the evi-

[1] Hugh Rodman Leavell and E. Gurney Clark, *Textbook of Preventive Medicine* (New York: McGraw-Hill Book Co., 1953), p. 7. *See also* pp. 1–102 and 290–321.

[2] Commission on Chronic Illness, *Proceedings of Conference on Preventive Aspects of Chronic Disease*, Chicago, March 12–14, 1951, pp. 31–32.

[3] John A. Clausen, "The Ecology of Mental Disorders," in *Symposium on Preventive and Social Psychiatry*, Walter Reed Army Medical Center, (Washington, D. C.: 1957); Commission on Chronic Illness, *op. cit.*; R. H. Felix and R. V. Bowers, "Mental Hygiene and Socio-Environmental Factors," in *Backgrounds of Social Medicine* (New York: Milbank Memorial Fund, 1949).

[4] Erich Lindemann, "The Nature of Mental Health Work as a Professional Pursuit," in Charles R. Strother, ed., *Psychology and Mental Health* (Washington, D. C.: American Psychological Association, 1956), p. 145.

dence around a physical or social disability. Making use of accepted principles of practice, the physician and social worker carry through with treatment techniques which restore the patient and client to normal or accommodated physical and social functioning. For public health practice a somewhat different framework has been established. This is a framework of operations suggested by the terms *study, control,* and *prevention.* A given health problem is carefully studied. Active measures are developed for control, while the health officer moves concurrently to establish some means of prevention which will alleviate or eliminate the problem as a factor in human life. In the history of medicine and science, among the most familiar and dramatic results that illustrate the successful application of public health methods are the drastic reduction of typhoid fever through discovery of the source of infection and agents of transmission; the conquest of malaria, when adequate control measures are taken; and, more recently, the development of a specific vaccine for poliomyelitis. The important clue to successful action in the case of these several illnesses is the availability of properly equipped research personnel to study problems of etiology and the natural history of the disease with a view to eliminating it at the source or intervening at some point in the transmission line to prevent its devastating results. It has been found—as in the case of the Salk vaccine—that availability of the means of prevention is not enough. There must be an intensive educational program or people will not avail themselves of the benefits of a scientific discovery, even when their own health is involved.

The problem for our profession is that it has not yet come to grips with the possibilities of developing a preventive social work that will make the best use of the knowledge developed in related fields. It is clear that any one profession cannot make use of the findings, skills, and knowledge of another simply by taking over its methods. The possibilities for adaptation, innovation, and creative use of knowledge from outside social work must be pursued if the profession is to avoid continuing along the same endless cycle, involving maximum use of its skills at the wrong end of a social system which is producing a large volume of social pathology. As stated in a recent Russell Sage Foundation annual report:

> The problems of the broader community and the societal context to which the social welfare professions must address themselves are as yet not receiving adequate attention from social work practitioners. A public health model available in the field of medicine has no vigorous current analogy in social work.[5]

Many will agree that some analogy should be developed, and the quest for it should begin to attract more of the personnel and financial resources of social work. There are visible difficulties in the adaptation of prevention as it is known in other fields. In public health there is physical intervention, made possible through knowledge of causation or the agents of transmission of a specific illness. In social work there is less that is concrete to work with in terms of illness. However, the methods developed in preventive psychiatry do lend themselves to application in social work and should be examined closely to determine their usefulness.

In order to pursue this question further and relate content in the field of public health prevention to the field of social work, it will help to review briefly what are referred to as "levels of prevention." In preventive medicine these have been described as: "(a) health promotion, (b) specific protection, (c) early recognition and prompt treatment, (d) disability limitation and (e) rehabilitation." These are not seen as "static or isolated phases in the natural course of the disease process" but as a continuum.[6] In another source, dealing with application of control methods to mental

[5] Russell Sage Foundation, *Annual Report, 1958–59* (New York: Russell Sage Foundation, 1959).

[6] Leavell and Clark, *op. cit.,* pp. 31–32.

illness, the levels of prevention are postulated as primary, secondary, and tertiary. Stated in direct terms, primary prevention deals with "what we know how to prevent," secondary with "terminating or mitigating illnesses that we know how to terminate or mitigate," and tertiary prevention with "the reduction of disability suffered as a result of illness where we know how." [7] It is the main thesis of this paper that in the field of social work we are presently devoting our main effort to areas of secondary and tertiary prevention and are doing very little at the primary level. A second and equally important consideration is that continued emphasis at the secondary and tertiary levels may result in acceptable and enduring accomplishments, but will not bring us closer to long-range solutions of old social problems.

It is interesting that in preparing a statement on the functions of social work Boehm lists restoration first, provision of resources second, and prevention third. While he notes that there is assumed to be interaction between the three, it is obvious that the main emphasis is on restoration.[8] Moreover, it is significant that the 1960 *Social Work Yearbook* has no listing under "prevention" or "preventive social work." This suggests that the field of social work, in general, is chiefly concerned with the *treatment end of the service spectrum* and less with the prevention end.[9] It is true that in the area of treatment the social worker has something concrete to grasp and a tested methodology to apply. This is the tangible and obvious and more easily understood part of professional knowledge and practice. The application of skills in the realm of prevention is less clear and attracts less attention from the average social work practitioner. In order to develop a systematic framework for prevention in the field, we must take a look at present-day attitudes and the culture in which social work functions. The increased application of prevention carries very serious implications for the client group, for the practitioner himself, and—finally—for social work education. These will be examined in turn.

PREVENTION AND THE SOCIAL WORK CLIENTELE

If one were to divide the population of the United States arbitrarily into three main groups, it might be easier to look at the issues involved in prevention and the social work clientele. At any given time there are the socially ill, the socially healthy, and the practitioners who provide the services. At present, social work practice is dealing in the main with the socially ill. If prevention results, it is at the secondary or tertiary levels. In social group work it could perhaps be said that services are provided to the socially healthy and that the result is, in a sense, primary prevention. The services of social work have traditionally been made available through agencies set up to serve the vulnerable segment of the population. In public assistance categories of service we have some notion of the socially and economically dependent groups (but not all). In the court system we have some clue as to the socially pathological groups (but not all). In the school system we have access to children of all ages who are in need of help and accessible to social services. Without going further, it is easy to demonstrate that we have only touched the surface of service needs in this country. Hence the question: Should we not be working to a greater extent with the socially healthy with a view to maintaining social health? Have we made the greatest possible use of case-

[7] Ernest M. Gruenberg, "Application of Control Methods to Mental Illness," *American Journal of Public Health and the Nation's Health*, Vol. 47, No. 8 (August 1957), p. 944.

[8] Werner W. Boehm, "The Nature of Social Work," *Social Work*, Vol. 3, No. 2 (April 1958), pp. 10–18.

[9] Virginia R. Hannon reports that earlier texts on social work listed chapters on prevention whereas the later volumes do not. In "Prevention in Social Casework in Historical Perspective and Present Practice," unpublished paper prepared for the Program of Advanced Study, Smith College School for Social Work (1949), p. 5.

work skills in what Gruenberg refers to as "anticipatory counseling and preventive analysis?" [10] Are we stationed at the right points, in our work in the familiar institutions of the hospital, health department, school, court, and rehabilitation agency? Might not the same skills of casework, group work, and community organization be used for early detection and early treatment, at a more profitable point in the cycle of health-disability than is now the case?

In assessing the impact of prevention on the client group, it is interesting to note that we do not today have in the United States really good statistics on the people served through social work programs. We know, for example, the annual case load of family agencies that are members of the Family Service Association of America; likewise, the number of patients who are residents in any given year in mental hospitals which report statistics to the Public Health Service. However, the first by no means indicates the total volume of family casework services in the United States, and the second does not provide good data on the volume and nature of service offered by social workers in mental hospitals. We do, because of systematic reporting devices, have a fairly accurate picture of the types of psychiatric classifications in patients receiving treatment in mental health clinics and mental hospitals. We have no similar classification of social disability or disorder in individuals and families, and no really satisfactory classification system has yet been evolved. This question is raised not merely for the sake of the statistical evidence such a classification would provide, but because a cardinal point in epidemiology deals with the need to know what one is measuring in terms of incidence and prevalence. Buell has persistently pointed to the need for better measurement of social pathology on a systematic basis.[11] He is, however, more pessimistic than this writer about the possibility of successful application of social work to the problems of primary prevention.

In looking at the client group that might be served by preventive social work, it may be necessary to re-examine the context in which we define "client." A user of preventive social services might well be a person from one's own profession, a related profession, or an individual who is not physically, mentally, or socially ill but needs counseling help. For example, are members of a family life education group in a social agency seen as clients? What additional skills does the caseworker need that are not now being taught as part of professional education? With the increase in work with groups and the growth in demands for consultation, the impression is rapidly growing that a more comprehensive type of educational experience is needed for the social work practitioner.[12]

The reason for dwelling on the subject of clientele is to shed some light on the problem of the focus of social work professional effort. As long as the focus remains on the disabled alone, so will the scope of practice remain limited. If the scope of professional effort can be enlarged to include a new client group—namely, the socially healthy—what, then, might be the prospects for substantially increasing the long-range value of social work to the community? We have knowledge of decades (or centuries) of dealing with crises in human welfare; how can we use it to relocate the focus of application of social work skills? Where do the problems show themselves? How *anticipate* breakdown? How can we use our skills to reinforce healthy ego-development, which we *know* is crucial to maintenance of healthy mental and social behavior?

What are the "points of entry" where preventive social work might be effective?

[10] Leavell and Clark, *op. cit.*, p. 309.

[11] Bradley Buell, "Is Prevention Possible?" *Community Organization 1959* (New York: Columbia University Press, 1959).

[12] Gerald Caplan, *Concepts of Mental Health and Consultation: Their Application in Public Health Social Work* (Washington, D. C.: U.S. Department of Health, Education, and Welfare, 1959).

Looking at the case load it would not be difficult to identify some of them. First, there is entrance into life itself. The experience of parenthood involves a complex variety of changes in the individual. Rarely in the literature of social work do we find any solid and effective relation between obstetrics and social work.[13] Another important change occurs with the entrance of the child into school. What reinforcing social services are built around the nursery school and kindergarten age groups? A third point of entry is that of adolescence. A fourth is marriage. These are the transition points which need close social work scrutiny and intensified research: birth, school entrance, adolescence, marriage. All can provide points of departure for constructive preventive social services.[14]

There is another order of transition which should become a magnet for our professional attention: population movement. A factor of psychological adjustment accompanies every physical move a family makes from one community to another. What is the ecology of the move to a new community? What are the counseling needs of the new arrival in a congested urban community or a new suburban community?

These matters will bear study. They suggest that the clientele of prevention might differ considerably from the clientele of treatment. They suggest that new adaptations of professional knowledge, attitudes, and skill might profoundly affect the breadth and depth of practice as we know it today.

IMPLICATIONS FOR THE PRACTITIONER

This leads naturally to the considerations that face the practitioner in social work and his preparation for professional service in this broader sense. The impact and implications of prevention for social work practice are covered in the document on prevention and treatment published by the National Association of Social Workers.[15] The point is made, among others, that casework alone does not provide all the skills needed for work in prevention; a broader competence is needed. From another angle, Cohen suggests that the community organization group needs to examine its practice if it wishes to assume a role in prevention. His comment is worth quoting for it brings us to one of the most frustrating aspects of any discussion of social work and prevention, namely, how to get at causation, or the etiology of social problems.

> If social work is to contribute to reversing the process of social disorganization, the effort must pervade not only the approach of the community organizer who has traditionally dealt with the larger social problems, but also that of the caseworker and the group worker. Community organization, however, has the major role to play and the implications for it should be quite evident. We are dealing, with the question of prevention in the full sense of the term. Location of the problem early enough to prevent it from becoming a larger problem is important, but not enough. The next step of utilizing our knowledge to prevent a problem from coming into being is essential. This means the willingness and the know-how to deal with cause rather than symptoms.[16]

The social context of a social problem is difficult to understand without some help from the social scientist. Hill looks at the family under stress from the standpoint of

[13] Florence E. Cyr and Shirley H. Wattenburg, "Social Work in a Preventive Program of Maternal and Child Care," *Social Work*, Vol. 2, No. 3 (July 1957), pp. 32–39.

[14] Dorothea McClure and Harvey Schrier, "Preventive Counseling with Parents of Young Children," *Social Work*, Vol. 1, No. 2 (April 1956), pp. 68–80.

[15] Bertram M. Beck, *Prevention and Treatment*, report based on the work of the Subcommittee on Trends, Issues, and Priorities, NASW Commission on Social Practice (May 1959). (Mimeographed.) *See also* "Clarifying Prevention in Social Work," *NASW News*, Vol. 5, No. 1 (November 1959), p. 9.

[16] Nathan E. Cohen, "Reversing the Process of Social Disorganization," in Alfred J. Kahn, ed., *Issues in Americal Social Work* (New York: Columbia University Press, 1959), pp. 138–158.

sociological analysis.[17] Adaptations to change and conflict may or may not be successfully made, depending on the inner strength of the family and its members. Another factor is the kind of professional help available to the family, which Hill points out may be scant indeed in some of the more rural areas. Worth noting is his interesting point that even a minor service at the right time may have important treatment value for the family. He is strong for supporting services.

> Counseling and casework become patchwork remedies unless a strong program of preventive social work and education is undertaken by agencies.[18]

The role of social work as part of an existing institution is perhaps best exemplified in the work now being done in school systems. Three research projects suggest that the school is insufficiently used as a screening resource to indicate social problems needing early attention.[19] Possibilities in the public health department for social work service directed at early intervention also need to be explored.[20] Are there others in direct contact with large segments of the population who are in trouble or headed for trouble and who might profit from social work service? What community institutions lend themselves most readily to the kind of professional service social work is prepared to offer? How open is social work to innovation and experiment? It has been suggested by Stevenson that

> Professional tradition appears as a block often in unexpected ways and places. . . . Tradition lays a heavy hand on progress at many points even after some student of the field has shown how expensive and handicapping it can be.[21]

It may well be that tradition serves as an obstacle to progress in developing prevention as an accepted role for social work.

Beck refers to "the price of prevention." It is his assumption that, in order to have preventive services provided by social workers, some sacrifice of existing service will be inevitable.[22] Perhaps such a risk is involved, but the same risks must attend the innovation of any new service which may not ultimately meet the need for which it was established. Nor do we know how many outdated and minimally useful services are maintained simply because of the bricks and tradition that surround them.

IMPLICATIONS FOR SOCIAL WORK EDUCATION

While it is true that social work education is fully dependent on practice for the definition and scope of services, it is also true that it has a distinct responsibility to make its own contribution to the improvement of practice. The university does not now have the counterpart of the university hospital and clinic for social welfare research and practice innovation. It must depend on the usual network of community social services for this purpose, and may therefore be particularly limited in the range of experimentation available to it. The cutting edge of the wedge leading to new developments in practice should be fashioned by both practice and education. More experimental agencies should be open to field instruction,

[17] Reuben Hill, "Generic Features of Families Under Stress," Social Stresses on the Family, *Social Casework*, Vol. 39, Nos. 2–3 (February–March 1958), pp. 139–150.

[18] *Ibid.*, p. 150.

[19] Erich Lindemann, "The Wellesley Project for the Study of Certain Problems in Community Mental Health," in *Interrelations Between the Social Environment and Psychiatric Disorders* (New York: Milbank Memorial Fund, 1943); "An Experiment in the Validation of the Glueck Prediction Scale," *Delinquency Prediction*, 1952–56 (New York: New York City Youth Board, 1957); Charles A. Ullman, *Identification of Maladjusted School Children*, Public Health Monograph No. 7 (Washington, D. C.: Federal Security Agency, 1952).

[20] Florence E. Cyr and Shirley H. Wattenburg, *op. cit.*; Elizabeth P. Rice, "Social Work in Public Health," *Social Work*, Vol. 4, No. 1 (January 1959).

[21] George S. Stevenson, "Search for Mental Health," *Children*, Vol. 3, No. 5 (September–October 1956), p. 79.

[22] Bertram M. Beck, *op. cit.*, p. 31.

and the universities should consider the advantages of some modifications in the types of learning experience even if some of the older and more established content must be modified or reduced. The agencies in the community that are taking the lead in preventive programs should be closely cultivated by the schools. This certainly means that the health departments and schools must be used more than they have been as field instruction agencies. There is no reason why the schools of social work should not even be directly concerned with the development of new and atypical agencies. The special screening and surveillance facility as a prototype merits more attention from social work. At the same time there should be careful analysis of innovations possible within the existing network of services.[23]

The significant development of group work in psychiatric settings emerged from initiative taken by schools of social work, and the momentum for growth continues to come from this source. There is little being developed at present under university auspices that suggests a direct approach to prevention.[24] The statistics on social work education consistently show that about 85 percent of all students at the master's level are taking field work in social casework. This very large proportion of the student group moves through the educational program in preparation essentially for treatment roles in social work. The model of the social worker as a treatment-oriented professional person is reinforced by the field instruction experience. His early practice years are devoted to extending and deepening casework knowledge and skill. The group work and community organization student tends to be taught how to function in *status quo* organizations and may have little knowledge of experimental agencies devoted to new approaches to practice. It may well be impractical to suggest that content on prevention become part of the social work curriculum until it has gained better acceptance by the faculty group in social work. Parsons refers to the singular responsibility of the professions for new developments.

> In terms of the social structure the central focus of the new process of innovation lies in the organization of the professions, with their special autonomy based on their expertness and their special relations to the system of higher education on the one hand, the complex network of implementing organizations on the other.[25]

Perhaps the reluctance to teach and apply the relatively unknown and unproved methods of prevention is a valid one. But this growing edge should be seen as a place for increasing investment of professional effort.

The careful analysis of typical cases seen in our present agency services may be one lead to the development of prevention as a method. If we look at the "points of entry," how might better services have helped at critical steps in the life cycle of the client? Where might anticipatory counseling have been helpful? Are there points at which the environment might have been positively affected through social work efforts? If we take a new view of who the client is, may we not find that we are called upon to serve a far broader group than at present?

There may be a need for broader experi-

[23] Milton Wittman, "Education for Community Mental Health Practice: Problems and Prospects," *Social Work*, Vol. 3, No. 4 (October 1958), pp. 64–70.

[24] An exception is the project on prevention now in its second year at the George Warren Brown School of Social Work, Washington University, St. Louis. *See* Ronda S. Connaway and Erwin H. Mellinger, "A Method for Assessing Causal Factors in the Problems of People: A First Step in Prevention." Unpublished master's thesis (June 1959).

[25] Talcott Parsons, "Professional Training and the Role of the Professions in American Society," *Scientific Manpower 1958*, papers of the Seventh Conference on Scientific Manpower, Symposium on Demographic and Sociological Aspects of Scientific Manpower (Washington, D. C.: U.S. National Science Foundation, 1958), p. 86.

mentation with agency structures. A multipurpose agency may yet be developed which will effectively handle the full range of social problems in the community, and also contain a unit devoted to prevention as its sole purpose. Or perhaps this function will be developed within the framework of an existing agency structure. It is certain that some new social invention will be needed to achieve this goal, for our present structure lacks the means of accomplishing it. We shall find without doubt that some interdisciplinary collaboration will be necessary in the evolution of preventive social work. As we have made successful adaptations from psychology and psychiatry (including psychoanalysis) in the practice of social casework, perhaps the next step is to create similar adaptations from public health and social science which will result in extending services in somewhat different functional arrangements. That prevention as a goal is the responsibility of an agency as traditional as the family agency is underscored by Davies, who points to the need to

> . . . utilize research skills to draw out and formulate from our practical working experience and know-how the basic principles of what makes for success or failure in family living, in marital relations, and in parent-child relations. Thus we can make our important contribution to knowledge that can be shared with families generally in a preventive and constructive way.[26]

IS PREVENTION FEASIBLE?

This paper has elaborated on the issues involved in applying prevention in social work. It has discussed developments in other fields and has acknowledged the difficulties involved in dealing with social pathology from the standpoint of prevention as compared with more easily accessible and visible physical illness. We have seen that the large body of social work practice today is oriented to treatment services, and that very little professional social work effort is devoted to practice in prevention. Little has been evolved in the way of literature on prevention, and this reflects a lag in interest and development that calls for study and analysis. There may be some adaptations of knowledge from other fields that can be helpful.

In public health and preventive medicine there are now well-formulated procedures and levels of action that can form a basis for preventive programs. In social work these cannot be used until there is better mastery of the philosophy and purpose of prevention. The scope of service coverage is one distinct barrier. Until there is some extension of coverage to the *total* population, rather than to the social work clientele as we know it now, we shall remain committed to secondary and tertiary levels of prevention which inevitably draw only upon the current range of treatment modalities. The major concern for the near future should be to develop adaptations of current practice which will reach more of the healthy segment of the population and may thereby retard the rising incidence of social pathology. How feasible such a projection may be will depend on research and experimentation with the several social work methods in a variety of communities.

Some notion of the educational requirements for work in prevention may be obtained from practitioners directly involved in such activity.

> It is recognized that the concept of prevention need not be confined to programs established exclusively for this purpose. However, in order to do preventive work, the social worker needs to have special understanding and knowledge about the normal or usual experiences of life. It has been relatively easy to identify pathology, but less easy to make a differential diagnosis as to when a normal life experience may become pathological.[27]

[26] Stanley P. Davies, "The Family Agency's Contribution to Mental Health," *Social Casework*, Vol. 32, No. 2 (February 1951), p. 66.

[27] Florence E. Cyr and Shirley H. Wattenburg, *op. cit.*, p. 38.

It is significant that the project from which this statement emerged was supported by grant funds and was not continued as a regular service by the institution sponsoring it. Obviously the feasibility of preventive programs depends on properly prepared personnel and adequate financing. These can come only when the professional group itself sees the favorable possibilities in prevention programs and is willing to promote them.

The profession stands today at the brink of a vast opportunity to make good its greatest usefulness to society. The field should work diligently to develop a segment of its manpower for preventive social work. It is a sphere of effort which should be shared by education and practice together. Only in this way can a new generation of social workers learn to apply social work skills in an attack on the roots of social problems. This move is long overdue and should have our serious, considered attention.

BY ARTHUR BLUM AND NORMAN A. POLANSKY

Effect of Staff Role on Children's Verbal Accessibility

IN PRINCIPLE, THE totality of the treatment situation provided by an institution for emotionally disturbed children is as susceptible to rational design and control as is individual psychotherapy. Putting this principle into practice, however, is extremely difficult. Among other things, we need a good deal more systematic information than we now have about the varying effects upon children of the many possible patterns by which staff responsibilities are organized and administered.

This paper will report research which serves to highlight one important aspect of the problem: What is the effect of the way a staff role is structured on the child's verbal accessibility to the staff member in that role? The term *verbal accessibility* has received explicit theoretical treatment elsewhere.[1] For present purposes, it will be adequate to think of it as referring to the child's freedom to communicate important feelings to a specific person. Previous research in the same setting from which the present results are drawn has shown (1) that the child's verbal accessibility in casework treatment is a stable feature of his personality, and (2) that there is noteworthy uniformity among the children with respect to the areas of feeling which are made more or less accessible. For example, *restraints* against communicating attitudes toward one's family and about one's self-image tend to be higher among all boys in this institution.[2]

The importance of communication in the treatment institution scarcely needs emphasis among those experienced in such settings. In analyzing the specific goals of a "therapeutic milieu," Morris Schwartz notes that it will "facilitate [the patient's] realistic and meaningful communicative exchange with others."[3] Although this was written with adult patients in mind, the criterion would apply equally to children in

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[1] *See* Norman A. Polansky, Erwin S. Weiss, and Arthur Blum, "Children's Verbal Accessibility as a Function of Content and Personality," *American Journal of Orthopsychiatry* (in press). Important contributions to an understanding of the phenomena involved in verbal accessibility have been made by Rickers-Ovsiankina and Kusmin and by Jourard. *See* Maria A. Rickers-Ovsiankina and Arnold A. Kusmin, "Individual Differences in Social Accessibility," *Psychological Reports,* Vol. 4, No. 4 (1958), pp. 391–406; Sidney M. Jourard, "Self-Disclosure and Other-Cathexis," *Journal of Abnormal and Social Psychology,* Vol. 59, No. 3 (November 1959), pp. 428–431.

[2] Norman A. Polansky and Erwin S. Weiss, "Determinants of Accessibility to Treatment in a Children's Institution," *Journal of Jewish Communal Service,* Vol. 34, No. 2 (Winter 1959), p. 133.

[3] Morris S. Schwartz, "What Is a Therapeutic Milieu?" in M. Greenblatt, D. Levinson, and R. H. Williams, ed., *The Patient and the Mental Hospital* (Glencoe, Ill.: The Free Press, 1957), p. 131.

treatment. One aim of this study of verbal accessibility, therefore, has been to gain some insight into how the child's readiness for intimacy relates to the social arrangements in the environment of his treatment. However, so interpenetrating are all aspects of a treatment milieu that, as the reader will note, research on the dimension of verbal accessibility necessarily involves us in a variety of other issues of staff organization whose effects might also be studied from other, more familiar angles. Concentration on the issue of readiness to communicate, as such, does appear to have brought some chronic issues in this complex field into sharper focus.

SETTING

Bellefaire, the institution in which the research has been carried on, has facilities for the treatment of about 100 emotionally disturbed children of the latency and adolescent years. Since its pattern of staffing is rather typical for such medium-sized institutions, only those aspects will be described that have most relevance to the present study.

At Bellefaire the children live in cottages ranging in population from about 12 to 16. Cottages reflect sex grouping and correspond also rather closely to chronological age. Each cottage is under the supervision of a *unit worker* (a trained caseworker or group worker), who has a kind of practical-therapeutic responsibility similar to that of the administrative psychiatrist in some adult hospitals. The unit worker has considerable authority over privileges and punishments, vacation planning, and so forth in addition to responsibility for the child's over-all physical care and trying to relate his day-to-day handling to over-all therapeutic planning. The cottage is usually staffed by three full-time *cottage counselors,* as well as some who work part-time and are used for relief. The cottage counselor, under the unit worker's supervision, has much to do with direct child care functions, as well as arranging recreation, maintaining order, and the like. Cottage counselors have extensive contact with the children, including such critical hours as going to bed, getting up, and meals. In general, much emphasis is placed at Bellefaire on making the cottage a meaningful and cohesive social group for the child.

A majority of the children are regularly seen in treatment by *caseworkers.* The casework is analytically oriented, involves once-a-week contact in most instances, and ranges from supportive to exploratory and/or insight treatment, depending on the child's readiness. Much staff thought and careful planning have gone into the design and redesign of the caseworker's role at Bellefaire, with the intention of keeping lines of communication with the child as open as possible and facilitating the emergence of transference elements in the relationship, while reducing complications in their management. For example, a preliminary survey indicated general staff agreement that, while caseworkers had the right to be fully informed of the child's communications to any other person, the caseworker was expected to be selective in what he shared, and could appropriately safeguard the confidentiality of his hours with the child.[4] The unit worker's role responsibility for many reality decisions has been mentioned above; to this might be added that many aspects of environmental manipulation (*e.g.,* medical appointments and even contacts with parents) and handling of immediate reality (*e.g.,* uncontrollability in school or even unwillingness to go to one's casework appointment) are typically discussed by the child with the unit worker in this setting. Similar discussions of reality issues also occur with at least a proportion of counselors. A study of attitudes toward *receiving* the child's communications shows that members of the cottage staffs discriminate about things they will discuss or even listen to. Thus, if the child talks about feelings around planning

[4] Unpublished survey made with Erwin S. Weiss.

for a parental visit, they may discuss these with him. But if he begins to bring up things out of the past which they sense to be important for the individual work, the general policy is to suggest he take these to his caseworker. Again, as anyone familiar with treatment institutions knows, no policy receives support from all persons 100 percent of the time. Nevertheless, these matters have received thorough examination throughout the staff, and the attitude that one supports them, or thinks he *ought* to support them, is general.

Some of the children attend public schools of the community, but most receive their schooling in a special school on the grounds of the institution. Hence, another significant role for many of the children is that of *teacher*. A high percentage of the children, of course, show learning difficulties as well as problems of behavior and concentration in the classroom. Although conducted with the needs of these children in mind, school is by common consent an arena in which reality demands are made. Incidentally, it is atypical for our children to be really indifferent to inability to perform in school, and there is prestige attached to attending regular school off the grounds.

These, then, are the significant features of the role definitions we have studied in this institution. The next question is how these arrangements affect the child's attitudes about communicating with the persons in these roles.

METHOD

The data were collected by an interview survey of all the boys resident in Bellefaire at one point in time. Following several days of continuous contact with each cottage to familiarize the boys with the interviewer as a person and to orient them to the study, the interviewing was conducted by Arthur Blum. The data relevant for present purposes were collected as follows:

1. Each child was asked to name the person who was, for him, his "most-trusted adult." Specifically, he was asked, "What adult at Bellefaire out of all the adults, any place on the campus, would you trust most to tell the things that bother you—your problems, your worries, and so forth?" The person identified in this way is here called the *adult confidant*.

2. Each child was also asked to identify his "most-trusted peer" from among his friends at Bellefaire.

3. Next, there was an exhaustive inquiry designed to get systematic measurement of "with whom the child would discuss what." That is, a topic was mentioned and the child was next asked, "Would you or do you talk about it to ———?" mentioning each of the persons indicated above as playing significant roles in each child's life situation: his caseworker, unit worker, each counselor, teacher, most-trusted peer; and most-trusted adult if not in one of these standard roles.

The topics inquired about included attitudes toward people significant in the child's life and concerns which were already known from preliminary work to be widely prevalent among these boys. The list was as follows:

A. Attitude toward caseworker and casework
B. Attitude toward "yourself" as a person
C. Attitude toward one's family
D. Attitude toward adults around Bellefaire, other than the caseworker
E. Attitude toward one's teacher
F. Attitude toward school
G. "Painful feelings," generally
H. Breaking rules (institutional infractions)
I. Misbehavior (things one actually feels guilty about, oneself)
J. Dependency deprivation (occasional feeling that no one cares about one)
K. Aggression initiated (hurting someone else)
L. Aggression experienced (that someone else had hurt the child)
M. Powerlessness (the feeling that one is

really not able to do things as well as others —is not as adequate as others)

I through *M* refer to attitudes of deprivation, worthlessness, and hostility which are prevalent problems among these boys.

All boys currently resident in the five boys' cottages were interviewed. In addition, sociometric and near-sociometric measurement was conducted to obtain a view of clique and power structures of the peer groups in each cottage.

Especially in such direct meaurement, a major concern is the validity of the answers obtained. From other data several checks were possible, and they proved encouraging. Thus, the boys who reported themselves as open about more areas to their caseworkers were also rated higher on scales measuring verbal accessibility which the caseworkers completed independently ($p < .02$). The staff members most frequently named by the boys as adult confidant were identified by unit workers previous to the interviewing as probably showing up in this way. Hence, there is adequate evidence that the boys gave serious and honest answers to the questions posed.[5]

Nevertheless, it is important also to be clear about what this technique did *not* measure. It did not assess the intensity of the communication made available in each instance. It could not assess readinesses of which the child is unconscious, or of which he prefers to be unaware. It may or may not reflect the state of the transference—this cannot be assessed in any simple way from verbal behavior. Obviously the question of whether the person to whom the communication occurs makes therapeutic use of it is not at issue in the present measurements.

RESULTS

In the interest of brevity and readability, the presentation of results was organized around a series of general conclusions derived from the study. These were arrived at inductively, after much sifting of the evidence. We had, ourselves, few preconceptions about what we would find when the study began.

The likelihood of being chosen adult confidant is, in this institution, heavily influenced by involvement in the cottage's direct care functions.

The question used in discovering the adult confidant was aimed at identifying the person with whom, as the child saw it, restraints on communication were at a minimum. One is curious, of course, about the staff roles in which these persons are found. Table 1 summarizes the choices made.

TABLE 1. DISTRIBUTION OF ADULT CONFIDANT BY STAFF POSITION

Staff Position Chosen	Number of Children	Proportion of Children
		%
Own cottage staff (*i.e.*, unit worker, full-time counselors)	44	59.4
Caseworker	17	23.0
Others *	10	13.5
No one	3	4.1
Total	74	100.0

* Includes six choices of a counselor from a previous cottage (*i.e.*, prior to transfer), plus one each for teacher, Boy Scout leader, summer counselor, residential director.

From Table 1 it is evident that *cottage grouping* plays a dominant part in selections of the adult confidant. At a later point we shall discuss "special personalities" much chosen among the cottage staff; it is noteworthy, in the present connection, that not one of these was singled out by a child *outside* his *own* cottage as "most-trusted adult."

The next most frequently chosen group are the caseworkers. The discrepancy in this kind of popularity polling is more apparent than real, especially if one recognizes the enormous differences in actual time spent together and that, purely statistically, the

[5] We are grateful to Dr. Mayer and Lawrence Grossner and their staff for the help in careful screening of the instrument and in the preparation of the children which made measurement feasible and evidently successful.

odds of choosing a significant adult out of the cottage staff as against one's caseworker are, by the laws of chance, 4 to 1. Nevertheless, the debate about the role of the person doing individual treatment as opposed to those "living with" the child is a lively one —especially among persons who read and write the literature of treatment—and we shall return to this issue below.

By a combination of education and allotment of functions the children can, to a noteworthy degree, be led to discriminate among staff roles in terms of the content appropriate to each.

Another question one might pose is whether the child's report about the recipiency opportunity of the various staff positions is done impressionistically or reflects a process of reasonably careful selection of content which he sees appropriate to some and not to others. Similarly, one might wonder whether staff intention in structuring various roles actually does, or does not, seem to get across to the children. This question can also be examined in the light of data available from the study. The two staff positions most frequently chosen as adult confidant are those of a counselor in the child's current cottage and his caseworker. In Table 2 is reported evidence concerning the relative recipiency opportunity of persons in each of those two positions. In the first two columns, there is a comparison between caseworker and counselor where *each* has been chosen as adult confidant. The entries consist of percentages of children, in each instance, who report themselves as willing to discuss a given attitude with the adult confidant. Although in this unique relationship the caseworker appears to have somewhat the edge, actually as concerns 12 out of 13 possible items, the differences are not significant. The caseworker-confidant is more likely to be told feelings about one's teacher. In other words, where there is a special relationship developed to the adult, his *formal* staff position makes little difference.

But how about the situation in which the relationship is *not* a special one? What happens if one takes the group of children who had a caseworker regularly assigned, but did not choose him as confidant, and compares reported openness to the caseworker with that to a counselor from one's cottage *other than* the one chosen as adult confidant? In this instance, we are able to compare two "standard roles" with each other. The third and fourth columns of Table 2 show the results of this comparison for 47 children in

TABLE 2. CONTENT REPORTED ACCESSIBLE TO CASEWORKERS AND COUNSELORS

Attitude	Proportion Open to Confidant		Proportion Open to Nonconfidant	
	Caseworker	Counselor	Caseworker	Counselor
A. Caseworker	.76	.68	.62	.36§
B. Self	.82	.73	.70	.43‡
C. Family	.88	.70	.79	.32•
D. Other adults	.94	.73	.68	.34†
E. Teacher	.94	.59†	.77	.32•
F. School	.88	.68	.75	.34•
G. Painful feelings	.88	.68	.55	.21†
H. Rule-breaking	.59	.65	.53	.47
I. Misbehavior	.82	.76	.66	.34†
J. Dependency deprivation	.82	.81	.68	.38†
K. Aggression initiated	.65	.76	.62	.34†
L. Aggression experienced	.71	.86	.66	.41‡
M. Powerlessness	.76	.76	.64	.38‡
No. of cases	17	37	47	47

Symbols refer to levels of significance of differences: .001 • .01 † .02 ‡ .05 §

our sample. Significance was tested by the use of McNemar's change-score technique.[6] In all but one content area, openness is reported as greater toward the caseworker than to a counselor not specified as in a particular relationship—that is, in the standard role.

The pattern developed for comparing the caseworker with the counselor where neither is confidant was then used in making most of all possible comparisons among persons in standard roles for the child. Results of this analysis indicate that, as the children report them, the staff roles fall into a kind of partially ordered scale of accessibility to the child. When one looks at the staff positions as listed hereunder, differences between adjacent roles are not marked, but roles which are two steps apart are clearly differentiated by the children.

1. The role with the highest reported frequencies of openness in the largest number of content areas is that of *caseworker.* As indicated above, both role-definition and staff education of the children combine to produce this effect.

2. The role of next highest standing is that of *unit worker,* again a trained professional social work position. The caseworker is reported as having the greater accessibility to the child in three areas at statistically significant levels. These are: attitudes toward the family, feelings about self-as-a-person (self-image), and dependency deprivation. Previous research has indicated that, even in the casework relationship, restraints are greatest against communicating about parents and the self-image. One might well conclude, therefore, that the protection to the casework role offered by that of the unit worker is indeed "a difference that makes a difference" for the child's readiness to talk in treatment.

3. *Cottage counselor* ranks next. Lower than the caseworker on 12 out of 13 attitudes tested, it also ranks lower than the unit worker on 7 of the 13. Differences significantly in favor of the unit worker role included family, caseworker, "other adults," teacher, school, and felt powerlessness. We have mentioned the extent to which cottage staff, especially counselors, are singled out as adult confidants in this institution. However, the fact remains that when this special relationship does not exist, professional staff have the greater accessibility.

4. *Most-trusted peer* ranks next, clearly lower than unit worker, but not too distinguishable from the nonconfidant counselor. In two areas the counselor ranks higher: school, and aggression experienced. Since the object of choice here is the *most*-trusted peer a comment may be in order regarding the practice of amateur psychotherapy in children's settings. This was certainly a problem, at times, at such a hospital as Austen Riggs,[7] and it is mentioned as a problem also at the Menninger Foundation by Miller.[8] While it also goes on at Bellefaire, the implication is clear that most children do not favor sharing too much with the other children. Undoubtedly the staff-patient distinction is more easily maintained in a children's institution because it is also heavily reinforced by the age-role difference. This makes *some* environmental problems easier, but only some.

5. The *teacher,* as a position, has a pattern clearly reflecting its special functions in the institution. Thus, teacher is ranked significantly lower than nonconfidant counselor in 10 out of 13 areas; the positions are

[6] Direct comparisons between totals in Columns 3 and 4 of Table 2 cannot be made without violating the requirement for independence among cell entries in the chi-square test, since the same child provided data for both categories. Accordingly, significance was tested by treating the patterns as if they were changes in a test-retest situation. *See* Quinn McNemar, *Psychological Statistics* (New York: John Wiley & Sons, 1955), pp. 228 ff.

[7] Norman A. Polansky, Stuart C. Miller, and Robert B. White, "Some Reservations Regarding Group Psychotherapy in Inpatient Psychiatric Treatment," *Group Psychotherapy,* Vol. 8, No. 3 (October 1955), p. 260 f.

[8] Derek H. Miller, "The Etiology of an Outbreak of Delinquency in a Group of Hospitalized Adolescents," in Greenblatt, Levinson, and Williams, *op. cit.,* p. 429.

significantly reversed, however, with respect to communication of feelings about school. Most-trusted peer is ranked higher than teacher in three areas, but again, the teacher is the more likely recipient of communications of feelings about school. Teachers show up, as one might expect, on a more general question asking who the child *likes* at the institution. But according to present arrangements in which the teachers also participate, they handle primarily the feelings toward school and toward themselves.

Over-all, as we have noted, the data clearly support the conclusion that the children can be educated to discriminate among roles in quite meaningful ways, especially when the ideology about these arrangements is reasonably generally held and supported by the assignments of functions. This finding is extremely encouraging to the hope that a therapeutic milieu can be designed and, as it were, orchestrated.

OTHER POSSIBLE CONCLUSIONS

At the same time, the data could lead to other conclusions which may or may not prove warranted. For example, if, despite his other responsibilities, the unit worker can still sustain so much accessibility to the children, why is it so necessary to protect the "casework relationship"? We must therefore re-emphasize that a difference in favor of the casework role as now defined *has* appeared with respect to kinds of content which might be highly significant for exploratory or insight therapy. This is in addition to the fact that the management of the transference involves more than maintaining open channels of communication and could become enormously complicated by the reality responsibilities carried by a unit worker.

Organizational charts can be confused by the emergence of "special personalities."

So geared are members of the therapeutic professions to recognizing personality differences that it was felt worth while first to present the evidence that staff roles, as such, can have rather widespread meaning to the children in treatment. Nevertheless, it is reasonable to expect that, when there are a number of people all in roughly the same position, "special personalities" may come to one's attention.

There were twenty-one potential adult confidants for the total of forty-four choices to be made among the five cottages studied. Over half of these choices, however, went to just three persons, one in each of three different cottages. One is curious about the personalities of these three people.

We can report in this connection only that they are three quite distinct personalities, and indeed this may be their most distinguishing characteristic! The things they do seem to have in common are a sincere dedication to the work of treating these children and long experience at it. All three make themselves available as listeners; all three will "go to bat" for a child on matters of principle. Although when the research was begun the hypothesis was also considered that a noncommittal attitude might make for more readiness for the child to communicate, this does not hold for the three counselors identified. All combine warmth with firmness, and they make no bones about holding to values generally accepted in the community as applying also to children in treatment. What they *do* offer the child is reliability of response, whether or not it is the response he is trying to elicit.[9]

For those inclined to argue that untrained staff *can* substitute for professionals, it does seem worthy of note that such special personalities are, by definition and statistically, "rare birds." The average counselor, under his conditions of work, is much less likely to be chosen than the child's caseworker. One might also wonder whether the selection of a cottage staff member as confidant in some way drains communication energy from the casework relationship. It was pos-

[9] Again one is reminded of the parallel to an adult institution: Edith Breed, the head nurse, played a similar role for many patients at the Austen Riggs Center.

TABLE 3. PEER-GROUP STRUCTURE AND CHOICE OF ADULT CONFIDANT

Clique Membership	Caseworker	Cottage Staff	Others and Nobody
Cottage in-group	12	24	3
Cottage out-group	5	20	10
Power position *			
Upper quartile	8	7	2
Lower quartile	1	6	6

* The ten boys who did not have caseworkers were omitted.

sible to check this in the data by examining the cases in which a child who had a regularly assigned caseworker nevertheless chose a counselor as confidant. No significant differences were found. That is, the child still describes himself as equally ready to communicate to his caseworker, even though the latter is not identified as confidant. However, since the reverse is also true, the potential does exist that these children may express to the counselor things one might prefer to have them reserve for the casework relationship.

In our institution, the child who deviates from the normative pattern in choosing the confidant is likely to be marginal to the peer group as well.

Polsky has recently given us a description of a spontaneous group formation in one children's institution with all the attributes of a typical delinquent gang.[10] Such structures are frequent in institutions serving delinquent youngsters. Once formed, these groups can be used in both group and individual resistance against treatment. It is difficult, of course, to know whether they actually are so used, since frequently they exist with at least the passive acquiescence of the staff in most direct contact with the boys, and the matter of *what* is being resisted is indeterminate. Nevertheless, they suggest the general hypothesis that in all treatment institutions those formations which occur spontaneously among the patients are likely to serve, at least in part, as resistance maneuvers. This hypothesis, which can be derived from the general theory of resistance in treatment, is certainly plausible, and we have made several attempts to investigate it in this research.

One might expect, for example, that in the informal group life of the children the tendency to use the group in support of resistance maneuvering would express itself in such a way that those with greatest group acceptance would also represent the least readiness to use the treatment environment. Opposed to this hypothesis is the possibility that children who have benefited and/or are benefiting from treatment will be showing a kind of integration which would also affect their group status. A comparison of choice of confidant with group status is given in Table 3.

From this table it can be seen that in this institution children who are members of the "in-group" in their own cottages [11] and/or to whom more group power is attributed by the other children [12] are more—not less—likely to choose the caseworker as confidant.

[10] Howard Polsky, "Changing Delinquent Subcultures: A Social-Psychological Approach," *Social Work*, Vol. 4, No. 4 (October 1959), pp. 3–15.

[11] Data were collected and analyzed in a pattern identical with that employed previously with adult patients, as described in N. A. Polansky, R. B. White, and S. C. Miller, "Determinants of the Role-Image of the Patient in a Psychiatric Hospital," in Greenblatt, Levinson, and Williams, *op. cit.*, pp. 389 ff.

[12] Techniques of data collection and analysis were similar to those previously employed in a camp for disturbed children. *See* Ronald Lippitt, *et al.*, "The Dynamics of Power: A Field Study of Social Influence in Groups of Children," *Human Relations*, Vol. 5, No. 1 (February 1952), pp. 37–64.

The children who make what are, in our setting, deviant choices—who are in effect marginal to the main stream of the treatment intention—are also marginal to their peer groups. These findings do not simply reflect shrewdness in assessing what the interviewer might have "liked to hear." Other data confirm that in the judgment of the caseworkers, too, these boys are actually more deeply involved in treatment. Consequently, it appears that in an institution serving primarily nondelinquent boys, and in which there is consistent staff support for the ideology of treatment, spontaneous group formations can and do occur in support of—rather than as a resistance to—treatment. The conditions under which one can be most hopeful of getting such group support, and for which children such support makes a significant difference, are obviously areas of great significance for future study.

SUMMARY AND CONCLUSIONS

This article has reported a study undertaken in an institution for the treatment of emotionally disturbed children. The focus of the study has been on factors in the treatment milieu which have bearing on the process of helping the child to make his important feelings available in treatment—his "verbal accessibility." The present paper reports some beginning clarifications related to the effects of the way in which staff roles are defined and communicated to the child by the institution.

It was found that by a combination of safeguards, staff agreement, and education of the child for treatment in a complex situation, he can be helped to make rather clear discriminations about which kinds of material to bring to which staff person. At the same time, it also became apparent that even under these conditions spontaneous intimacies and attachments are likely to develop to persons directly charged with care functions, which can act to complicate the most intensive individual work with the child. It is of interest that these complications are the more probable with members of the staff otherwise most likely to be "therapeutically helpful" in "the other twenty-three hours." In view of this, the data further emphasize one of the most interesting dilemmas of institutional treatment: What can and should be the role of the person doing the individual work vis-à-vis that of other significant personnel in the institution? Unfortunately, having brought the question into focus, we still cannot pretend to answer it. However, for the administrator interested in how various role relationships are working out in his own institution, one may suggest that the technique employed in this study is relatively cheap and appears to yield valid results when used by a person experienced with such children but seen as not part of the institution's own hierarchy.

BY NICHOLAS LONG, VICTOR STOEFFLER, KENNETH KRAUSE, AND CHARLES JUNG

Life-Space Management of Behavioral Crises

IN THE LATTER part of 1954 and early months of 1955, six boys between 8 and 11 years of age were admitted to a closed ward in the Clinical Center of the National Institutes of Health. They had been selected for their aggressive, hostile, antisocial adjustment, and for the next four and a half years were the subjects of a prolonged research study in the residential treatment of such children. From the outset their program included four hours a week of individual psychotherapy, special in-hospital school, and intensive milieu therapy with emphasis on "life-space interviewing" around disturbed behavior.[1] While the severity of their symptomatic behavior necessitated emphasis on programing within the hospital milieu, closely supervised experiences in the community were planned as often as possible. A caseworker assigned to the group maintained contact with members of each boy's family and arranged visits at the hospital or at home when either of these seemed advisable.

By July 1957, these boys had improved sufficiently to move out of the closed hospital ward into a specially built "halfway house," officially called the Children's Treatment Residence. This structure was located on the hospital grounds and was designed as an intermediate stage in the boys' socialization and treatment. During their two years' stay at the residence the boys became increasingly community-oriented through their attendance at public schools and participation in such community activities as teen clubs, Little League baseball, Boy Scouts, visits with friends, and so forth. At the residence they continued to live in a carefully planned milieu program geared to support and develop newly achieved gains, as well as to continue to provide protective limits on impulsive behavior. The boys also remained in individual psychotherapy. Inside of a short time one of them was well enough to be discharged, while the other five continued in treatment at the residence.

In the early part of 1959 we learned that for various administrative reasons our project would be terminating, and the boys were to be discharged sometime that summer. On Friday, February 13, 1959, this information was announced to them. In the following two weeks there was a progressive increase in quantity and severity of acting-out behavior.

The purpose of this paper is to illustrate how this increase in acting out was clinically exploited by means of life-space interviewing. Though our focus will be primarily on the interview technique, we recognize that the total impact of our treatment plan was the result of the combined approach of all

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[1] The life-space interview is a therapeutic technique developed by Dr. Fritz Redl in which the patient is confronted with his symptomatic behavior when an issue arises that can be clinically exploited in terms either of long-range treatment goals or of providing immediate ego support and emotional first-aid. *See* Fritz Redl, "Strategy and Techniques of Life Space Interview," *American Journal of Orthopsychiatry*, Vol. 28, No. 1 (January 1959), p. 29.

facets in our milieu. Individual psychotherapy, limit-setting, and special programing, as well as interviewing, contributed to the effect we obtained. This presentation will include a discussion of (1) *precipitating factors* in the series of acting-out incidents, (2) *strategy-planning* in the handling of these incidents, and (3) the *life-space management* of them.

PRECIPITATING FACTORS

On Friday, February 13, we announced to the boys that the residence would close that summer and they would be discharged. Some of the boys responded immediately with aggressive remarks, expressing mainly concern about leaving the residence and questions about possible placements. By Tuesday some acting out had begun. Ed became disorganized—sloppy eating habits, swearing, verbal obscenities, a disheveled appearance, and a "you-make-me" attitude appeared. He required a staff member with him constantly to help control his behavior. Tony stole some things from a neighborhood store.

The staff moved in with a highly structured program, tighter controls, and closer supervision. By Saturday some of the acting out had leveled off. On Sunday, however, after family visits which aroused anew feelings of separation from the residence, the boys again became nearly impossible to manage. Tony grabbed restricted dietary food off the table faster than we could tell him to stop. Bruce clung leechlike, and made impossible demands on everyone. Later in the evening when the program director asked the boys to turn off the TV and retire to bed, Ed blew up and kicked him.

The next day Ed's disturbance was so severe that we moved him to a closed ward in the adjacent hospital. This gave him the security and boundaries he needed. Because of staff concern with the management problems he presented, a staff meeting was held in which handling techniques were discussed. An outgrowth of this meeting was the conversion of our craft shop in the basement into a "settling room."[2] Arrangements were made for additional staff if this should become necessary. When Ed returned to the residence three days later, a highly structured program was prepared for him which included assigning him to a "special" —*i.e.*, a person who stayed exclusively with him and was totally responsible for his program and management.

The other boys perceived the attention given to Ed as a form of rejection of themselves. During the rest of the week they reacted both to their own feelings about separation and to the special attention being given to Ed. The latter returned to the residence on Wednesday and within four days each of the other boys had individually and collectively acted out. Tony stole from school and was more aggressive with staff members. Frank smoked and fought at school, missed his cab pickups from activities, and it was suspected that he was stealing at school and at the residence. Clif was involved in sex play with Frank. All the boys but Ed were involved in fire-setting, playing with matches, and other destructive behavior. Tony, Frank, and Bruce broke into the medical supply cabinet, damaged a blood pressure gauge, and took medical supplies. Only Ed remained out of it all, content and secure in his new program.

After a very difficult weekend, a shaken staff returned the boys to school on Monday. It seemed miraculous that there were no major problems at school during the day, but that night the acting out reached new heights. Bruce had a temper tantrum and had to be held for an hour and a half. The other boys, too, were anxious and presented difficult management problems: Clif pushed a counselor down some stairs; Frank was found smoking at the residence; Tony be-

[2] This was a room which had no windows or furnishings other than two mats on the floor. Here two or three staff members could comfortably restrain a boy, while he would neither destroy any property nor receive secondary gratification from acting out in front of the group.

came angry at a staff person when he was sent to his room, flew into a rage, pushed out his window screen, and broke his cupboard door. Ed, who had just returned from a closed ward, reported that someone had taken his foreign coins from his room. The senior staff member on duty recorded seven life-space interviews with the boys as he tried simultaneously to settle their immediate problems and keep them from inciting each other to new ones. The staff was becoming exhausted and it was obvious that something had to be done to cut through this steady increase in acting-out behavior.

PLANNING STRATEGY

By the next day at regular staff meeting, staff morale was low and concerns over the current increase of acting out, along with personal feelings about termination of the project, were freely expressed. Two of the staff members were on sick leave; others were fatigued to the point of demanding relief. It was understandable, therefore, that when this meeting opened, the predominant feeling tone was one of depression mixed with open hostility. The meeting started with the staff examining all the incidents that had occurred during the past week. A staggering series of incidents relating to each boy were grouped separately and recorded on the blackboard.

Once the incidents were listed, two questions emerged: (1) What were some of the underlying reasons that led the boys to act in this way? (2) What could we do, as a team, to help the boys become aware of these reasons while we sustained them and made them feel that we were not going to let them destroy the gains they had worked so hard to achieve?

After considerable debate, the staff decided to use a dramatic approach in order to shock the boys into looking at their behavior and to demonstrate to them the deep concern over their acting out. Accordingly, the following plan developed:

1. As the boys returned from school they would be met by a counselor, escorted to their rooms, and told that they would meet individually with the entire staff to discuss their behavior.

2. The housemother would bring each boy his regular after-school snack and try to reassure him if he was becoming upset.[3]

3. The living room chairs were to be arranged in a circle, with a large paper pad on a portable easel placed at one point in the circle. Each boy's name with the list of incidents in which he had been involved during the past week would be written on a separate page. Each boy in his individual interview would sit directly across from the easel and between the housemother and the social worker.[4] The rest of the staff would sit in the remaining chairs while the director stood next to the easel.

4. After his interview, each boy would return to his room with a counselor until all five boys had been seen. Then all the boys would be called down for a group interview to review what had gone on in the individual sessions, to emphasize the common problem of separation, to assign each boy a counselor and senior staff member for a follow-up life-space interview, to announce a limited special program for the next five days, to plan for a formal evaluation at the end of that period, and to answer any questions.

Despite ambivalent feelings about the plan on the part of various staff members, it was adopted and went into effect when the boys returned from school. As the boys returned to the residence, they were sent to their rooms, where they were told about the meeting. They complained about this restriction and threatened "to bust the hell out" if they were not allowed to leave immediately. They were reminded that this was the kind of attitude about which the staff was concerned, and were told that they would have to remain in their rooms until they were called.

[3] The housemother, Eve Citrin, a professional social group worker, lived in the residence and was the assistant director.

[4] The social worker, Walter Sceery, did casework with the boys' families and was responsible for finding new placements.

INDIVIDUAL INTERVIEWS WITH TOTAL STAFF

Since it is not possible in this paper to give a verbatim report of each interview, only the first is described in detail; the other four are summarized.

Frank is an intelligent, controlled, hostile boy who plays hard at being a tough delinquent. As he enters the living room, he is momentarily taken aback by the elaborate room arrangement and the number of staff members present. Slowly he counts the number of staff persons and says smugly, "Twelve against one, it looks like I don't stand much of a chance against this jury." The staff laughs and the director says, "While it may look like a trial to you, we are not here to pass out verdicts, but to see if we can understand what has been happening to all the boys these last two weeks." Frank asks in a hostile way, "Why are all the staff in on it?" The director explains that since this is such an important meeting, he has asked everyone to attend. The director points to the first page on the pad. On it is written the date, "February 13." "Frank," he says, "It's been a little over two weeks since you were told that the project is ending. Since that time there has been a lot of acting out. Let's take a look at the kind of situations in which the boys are involved. Perhaps you will get a better picture of how serious and alarming it is. What we want you to see is that this acting out of feelings is not just your problem but involves all the boys." At this time, the director slowly and seriously reads each list of incidents. Frank seems impressed by the lists and shows some genuine concern over the amount of acting out. When the director finishes reading Tony's list, Frank comments, "Humph, Tony is in worse shape than I am."

The director flips to Frank's page and says, "Why don't we go over your list again and see if there is any pattern to it." As the director repeats the items Frank slips into his delinquent defense and starts to argue that he was not involved in breaking the blood pressure gauge. The director replies that Frank will have plenty of time this evening to go over each of the incidents with one of the senior staff members. The director continues, "Frank, if you look at this behavior and compare it to the way you behaved four years ago, you'll notice a lot of similarity. It's really wild stuff and is seen in a locked ward and not in an open setting like this." The director pauses but Frank does not respond. "If we try to understand what is behind all this acting out it seems that some of the boys are saying, 'I can't trust you any more,' 'I'm getting the short end of it,' 'I'm being kicked out, so what the hell!' Perhaps these feelings are very close to the feelings they had when they had to leave their parents." Frank appears depressed. His head is bent and supported by his hands. The director continues, "We all know that this has not been easy on any of you boys. We know that you have questions about where you'll be placed, when you'll be leaving, and many other questions. If you recall, Frank, Dr. Noshpitz [5] told you that Walt (Walter Sceery, social worker) would be talking to you about your future plans." Walt describes in detail the one treatment residence he visited and gives Frank a list of the places he will see the following week. Walt adds that Frank's placement to some degree depends on his behavior during the next four months.

The director asks Frank if he has any questions. Frank hesitates and then asks Walt if he can find a place for him nearby. Walt answers that he has no way of knowing right now, but that his plan is to visit many places and select the one that will give Frank the most help. Frank accepts this, walks over to the easel, and reads his list of incidents. The director then asks Frank if he has any further questions. Frank replies that he does not and starts walking out of the room. Suddenly, he turns, walks to the director, puts his hand in his pocket, pulls out a cigarette lighter and says, "I found this in school today."

[5] Dr. Joseph Noshpitz, chief psychiatrist of the Child Research Branch, was the person who had announced the termination of the project to the boys.

The director accepts it and Frank returns to his room.

The other four interviews followed the same general pattern, although they varied considerably in terms of their effect on the boys:

Ed, 14 years old, weighing 216 pounds, was just back at the residence from a closed ward. He reacted to the pressure of the interview in a severely infantile fashion. He ran to his chair, sat down, grabbed the rungs, got up holding the chair as though it were stuck to his seat, and walked around the circle like an elephant. Finally he dropped the chair, made some animal sounds, rushed around the circle, and shook hands with each person. It was only after much assurance that we were not going to hurt him that Ed settled down. The director commented that Ed had just gone through a difficult period and that since his return to the residence he had been trying hard to maintain controls. Ed was able to ask several questions about placement. When they were answered, he seemed to realize that he was being taken care of and quietly returned to his room.

Clif, a tall, good-looking boy with a schizoid-like makeup, approached the meeting with a sullen anger. He glared at the staff during the first part of the meeting. The only thing that pleased him was Tony's long list of incidents. He laughed and said, "All the stuff isn't even there." Walt commented that he planned to see him and his mother every two weeks to plan for his return home. Clif said bitterly, "I don't wanna go home." Walt asked where he would like to go. Clif shouted back, "To hell." Walt commented on Clif's fear of returning home, but added that he had to face the fact that he had to go home. Clif answered, "I don't have to do nothing," and froze for the rest of the session.

Tony, like Frank, was overwhelmed by the number of adults, and responded by becoming very silly. When the director presented the material, Tony mimicked him, using baby talk. When the housemother refused to allow him to sit in her lap he clung to her. Tony asked why he couldn't go home like Clif. The social worker replied that his home would not be able to provide him with the help he needed. Tony became angry and said, "The way they treat me here, I'll never be ready to go home." Tony started to swear at the staff and had to be taken to his room.

The last boy seen was *Bruce,* who reacted to the session seriously and listened attentively. He asked what he had to do to get ready for a foster home placement. The social worker asked Bruce to see him after the meeting so that they could spend more time discussing this question. Bruce read over his list of incidents again and asked if he could tell the entire staff about his part in them. The director told Bruce that there was no need to make a public announcement and that he could wait and talk later with one of the senior staff members. Bruce then asked to have his interview with a senior staff member start immediately. He was told it could take place after the group session, and returned to his room.

GROUP INTERVIEW WITH TOTAL STAFF

According to plan, the entire group was called back to the living room after the individual interviews. Initially there was a great deal of confusion: Tony jumped on the backs of staff, Clif sat in a corner refusing to join the group, Ed crowed that he wasn't in any trouble like the rest of them, Frank threatened to punch Tony in the mouth, and Bruce screamed that the meeting should start. Finally, all the boys were sitting around the circle while the director reviewed the individual sessions, underlined the separation theme, and emphasized the need for the boys to pull themselves together. He stated that, in order to protect them from further difficulty, the boys would remain in the residence or in the immediate area for the next five days, except for the time they were attending school and their in-

dividual psychotherapy sessions. He further stated that at the end of this period each boy would be seen again to evaluate whether he had been able to gain some understanding of his part in the acting-out incidents and whether he was able to modify his behavior. Bruce wondered whether he could return to community activities if he worked everything out in two days. The director replied that it would take time to work through the problems and the earliest a boy would be allowed to assume responsibility for his own behavior in the community would be Monday. The director ended the meeting after answering a few anticipated complaints.

INDIVIDUAL LIFE-SPACE INTERVIEWS

After the group interview with staff, each boy was seen individually by a member of the senior staff along with the counselor who was to be with him during the evening. Generally, the goals for these life-space interviews were:

1. Interpretation of underlying anxieties as motivating factors in the acting out of symptomatic behavior—in this case mainly the feelings around separation, rejection, and sibling rivalry.

2. Resolution of the acting-out incidents, or at least open discussion of them, in order to relieve unconscious guilt which could in itself become a motivating factor for more acting out.

3. Demonstration of protection and security through the control of impulsivity, along with a feeling of adult interest and physical closeness which would serve as counteragents against the separation anxiety.

4. Discussion of separation feelings in order to set the tone for follow-up interviews.

Frank. One of Frank's major problems was the conflict between his identification with his delinquent social and family background on the one hand, and the value system presented by our institution on the other. In order to justify and maintain his delinquent image, Frank used an elaborate defense system employing techniques of denial, projection, rationalization, and displacement. In dealing with these defenses we were frequently in the difficult position of having to prove Frank's guilt in some given situation. If we could not do this Frank would perceive this as an admission of his innocence. This established, Frank would maintain that we had no grounds for pursuing an incident any further with him. If we persisted, we would be feeding his paranoid fantasy of the persecuting adult. Moreover, when Frank succeeded in his manipulations of us, his pathology was reaffirmed and our ability to help him greatly weakened. Worst of all, the omnipotence of the aggressive and hostile forces within were reinforced. We had learned through hard experience that we could work with Frank most effectively when we were able to avoid his manipulative defenses and approach him on the more vulnerable level of his underlying motivation. We could strengthen our approach by offering him protection from the dangerous breakthrough of his own aggressive impulses through a tightly structured program with clearly defined limits on behavior.

Thus, we handled the interview according to our pragmatic knowledge, avoided defensive traps, and mentioned areas of improvement since hospitalization as well as the upsetting factor of separation. As the interviewer made interpretations, announced limits, and outlined the program for the next five days, Frank's rigid posture and tense facial expression gradually relaxed. He curled into a fetal position on his bed and fell asleep shortly after the interview.

Ed. This boy had had his eruption the week before and was the only one not involved in the current episode of acting out. The interview was therefore designed to support what we could of Ed's observing ego, and to anticipate with him the potential stimulation from the acting out of the other boys. The interviewer planned with Ed a number of activities to support his positive self-image. By design, many of these took place in the community, where

Ed would be contagion-free from the other boys.

Ed's extreme anxiety concerning the interview diminished as he began to feel secure within the structure of the program and as he anticipated the gratifying activities. At the end of the interview, Ed responded with a determined, "Don't worry about me, they're not going to suck me into their problems," and left with his counselor for a trip to the store.

Clif. Despite Clif's hard core of hostility he was frequently able to behave pleasantly and acceptably. In interviews, and particularly in the face of confrontations, Clif related in two major styles: either by a flat response of indifference and unconcern along with total denial of affect, or by an eruption of hostility of such proportions that meaningful exploitation of the incident was impossible. The aim in this interview was to find some middle ground where a connection could be made between underlying feelings and acting-out behavior.

After meeting some initial passive resistance, the interviewer changed his approach and asked Clif if he recalled what made him push a counselor down some stairs the day before. Clif said that he did it because he was angry. The interviewer allowed that angry feelings made Clif do such things as pushing staff around and setting fires, but that there were better ways to handle such feelings. He suggested that Clif was angry partly because he had seen Ed getting a lot of attention following his "blow-up" the week before, and partly because he had been told that the residence would be closing and he would be going home. Clif said again that he did not want to go home, and followed this with many questions about his school friends, his baseball team, what would happen to the residence, the staff, and so on.

In contrast to his individual session with the staff, throughout which he remained sullen and hostile, in this interview Clif talked with some freedom about how he felt in the face of the impending separation. The interviewer assured Clif that the staff would help him learn how to cope with many of his difficulties before he left for home. Clif was able to accept this and the specialized residence program without protest.

Tony. Tony seemed to operate out of guilt patterns based on deep feelings of rejection and oral deprivation. As a rule, any stimuli which activated these underlying feelings provoked a wave of impulsive aggression. This in turn created more guilt, which led to even more acting out. The staff had found that the most effective way to break into this vicious circle was, first, to bring all the misdeeds into the open and come to some resolution of them through discussion, and then to interpret and try to handle whatever current pressures were stirring up the underlying feelings. Thus, a meticulous discussion of each of the thirteen incidents ensued. Resolutions for each one ranged from working out a system of repayment for broken items and planning for the return of stolen goods to labeling an incident as having been "out of line." All told, these resolutions required three interviews, each about forty-five minutes long, which took place throughout the evening. Tony, anxious to get out from under the load of guilt, pitched in co-operatively in working out each item.

After all of the incidents had been discussed, the interviewer spoke approvingly of Tony's participation, but added that they really hadn't touched on what was behind this behavior. Tony's reply was his stock answer, "I don't know, I just felt like it." The interviewer remarked that since the announcement of the discharge, all the boys seemed to feel that they were being let down and that we didn't really care about them. One could understand why Tony felt this way in view of all he had experienced with his parents and the many feelings that came from their rejection of him—the sense of not being wanted, of not being cared for or fed enough—and finally of being sent away. For a moment Tony looked startled and

sad, then quickly covered up this unusual display of true emotion with a strained grin. Feeling that no more discussion could be tolerated at this point, the interviewer briefly explained the specialized program and terminated the session.

Bruce. In order to protect a vulnerable core of dependency strivings, Bruce had developed a highly effective defense of manipulativeness. In action, he was a "behind-the-scenes" operator. He was frequently an instigator, indirectly involved but seldom guilty of the misdeed itself. He would often stimulate episodes of acting out, but he always withdrew at a strategic moment.

The interviewer began by enumerating the incidents that Bruce was involved in along with Frank and Tony. Bruce responded by claiming that he had been drawn into these incidents by the others through no fault of his own; which was true, insofar as it was the others who actually perpetrated the deeds. Bruce carried this line of defense to the point of creating an impression of having been threatened by the others as a potential squealer. He complained that staff were failing to protect him from the others; indeed, it almost appeared that we were the guilty ones rather than Bruce.

The interviewer said that all the boys, including Bruce, had been involved in these incidents and that maybe they all were reacting to the same thing—the prospect of having to leave the residence. She said that this was something all the boys had to face, and that we would help them with this problem as we had helped them with other problems in the past. The housemother answered Bruce's questions about possible placements and said that he would be kept informed of things as they developed. After talking out some of his concerns about leaving, Bruce was able to accept the housemother's discussion of his participation in the incidents.

FOLLOW-UP

Following the interviews, each boy spent the evening in the company of the counselor who had been assigned to him. The usual residence evening routines went smoothly and without incident. Through the next five days we conducted a special program. Since the boys could not go out for activities and we did not want them to view this restriction as punishment, we brought the activities to them. We provided some new athletic equipment, some quiet projects such as model-building, and two full-length movies which were shown during the weekend.

During this interval at least three life-space interviews were held with each boy. These sessions were intended to continue the working through of the various incidents, to lend the boys additional support, and to examine any further difficulties that might have arisen. Ed was seen once in order to interpret to him how the others had begun to scapegoat him in an effort to lure him into acting out.

Finally, on Sunday, each boy was interviewed individually to evaluate his behavior during the five days. In each session the interviewer recapitulated the causes of the boy's previous acting-out behavior, the behavior he had displayed during the last five days, and the progress he had or had not made. All but one were allowed to resume their regular schedule of activities; Tony seemed to need more time to work on his particular problems. In his evaluation, Tony was able to accept the fact that he would still be limited to the residence and would be closely supervised.

Aside from the lowering of patient anxiety, staff morale had been lifted considerably. It was generally felt that a combined staff effort had succeeded in bringing a useful therapeutic design out of what had seemed like complete chaos.

BY RALPH A. MAGNUS AND SIDNEY WASSERMAN

Three Neurotic Delinquents

THE DIAGNOSTIC MAKE-UP and treatment of the neurotic delinquent are closely related to factors in his background and history that must be carefully considered in order to understand how his psyche has been affected. Many such delinquents are boys who reveal signs of unusual potential, but because of the events in their lives have developed a tremendous degree of guilt and deep sense of worthlessness. Because of the inner and outer confusions in which they are enmeshed, their potential is realized only through self-defeating, socially unacceptable mechanisms. This paper will examine some of the circumstances that "fractured" the egos of three such delinquents, as well as processes and insights found useful in treating their problems. The authors offer some suggestions about techniques and approaches in rehabilitating the neurotic delinquent within a residential treatment center. Bellefaire, the center from which material for this article is drawn, is coeducational and has a population of 90 to 100 children. The age range is from 6 to 18 years.

MARVIN: BACKGROUND

Marvin, a 15½-year-old, was the oldest of three boys (brothers: Bill, 14, and Eugene, 6). He had experienced for years a disturbed relationship between his parents which had a growing impact on him. His mother performed a dominant, controlling role, requiring a subordinate position from her husband. She was seductive and encouraged Marvin to cling to her with undue closeness, thereby sanctioning in his mind a remoteness to the father. Because of the boy's unusual intelligence, she began pressuring toward premature and unreasonable success, narcissistically wanting to display these achievements. The father was unable to assert himself in this situation and relinquished his role through his admitted failure to meet her level of expectations or protect Marvin from these desires.

In his early school years Marvin functioned brilliantly, academically. At Eugene's birth he started downhill, stopping schoolwork and outside reading and becoming noticeably depressed. This was most perplexing to the parents, since there had been no previous overt reaction to the birth of Bill, some six years earlier. He seemed unable to hold back the anger that had been mounting within him. His mother added to it by compelling him to care for his brothers, stopping his allowance whenever he failed to fulfill the role of older, responsible brother. His mother spent hours at night in his bedroom, talking to him and urging him not to cut school. Amid pleas, tears, and kisses Marvin would promise to change, but the next day would go off in the direction of school and then head for the downtown movie house.

The climax of the mother's desire to have Marvin take a father role in the family came in her use of his Bar Mitzvah [1] money to move the family to a midwestern city. This directly preceded beginnings of overt delinquency. Shortly after their arrival in the

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[1] Confirmation, signifying the entry into symbolic manhood for 13-year-old Jewish boys.

new city Marvin began truanting, shoplifting, car-stealing, and involving himself with a delinquent gang. Upon the recommendation of the psychiatrist of the juvenile court, he came to the treatment center at the age of 15½. This recommendation was based on two and a half years of consistent contact with the court and detention home [2] (where he stayed several weeks before placement, after stealing a car and crossing the state line).

MARVIN: TREATMENT

In the first month of treatment, the boy made a "sweeping successful" adjustment. He was elected vice-president of the student council; he was popular with boys and girls on the campus as well as with staff members. However, with his caseworker he verbalized the fear that he would lose his "wild streak" in treatment because he would be left "half-dead, passive, with my guts taken out." After the "honeymoon period," Marvin began to team up with another acting-out, aggressive boy, and the two of them engaged in breaking campus rules, leaving the cottage without permission, getting drunk, and numerous runaways. Five months after placement, Marvin and his "friend" were placed in the detention home following a drinking episode.

Marvin was extremely anxious during his stay in the detention home. He feared he had ruined his chances of returning to the treatment center and would be sent to a reformatory. When the caseworker said he wished Marvin had thought of that before he got drunk, Marvin blasted, "Kiss my ass!" and walked out of the interview. When he was returned to the treatment center, he could not understand how he could be given another chance after showing such hostility to his caseworker. This experience helped tune Marvin to treatment. He began to reveal to the environment the pent-up aggression and bitterness which had hitherto been disguised and hidden. Slowly the hostility emerged in the casework interviews. It was noted that, though he improved in his ability to "listen" (becoming aware of the need to develop his own inner controls), he could not always "hear." The environment consistently had to support and impress upon him the need to do his own controlling eventually. As Marvin talked out his feelings of hurt and anger about being rejected by his parents, he then transferred this anger to his caseworker. In the cottage he began to establish a strong, positive feeling toward a cottage counselor who was a mature, middle-aged father-figure for him.

As treatment progressed, restrictions were lessened and emphasis was laid on placing the anxiety "in his lap" rather than carrying it for him. This was best illustrated in his performance as a newspaper boy. He had been able to peddle papers each morning only because the route man waked him up and anxiously covered for him when Marvin failed to get up and deliver. As Marvin said, "Better he should worry than me." It was apparent that he was becoming increasingly comfortable with this attitude and needed to have authority deny him the privilege. He was fired, and the environment made use of this reality to show him the consequence of this kind of behavior.

Marvin's greatest area of anxiety was manifested in school. After attending one semester at the treatment center school, he was enrolled in a public high school. Until his final year he was unable to achieve two successive semesters, and had to withdraw on two occasions because of his overwhelming fear of success. As he told his caseworker at the time of his first withdrawal from school, "Can't you understand? I've got to fail! I'm a disgusting, lousy, miserable, worthless person who can't succeed." During periods of anxiety and depression, he developed psychosomatic and imagined ailments, at which time he would retreat to the treatment center infirmary. Whenever the unit supervisor in his cottage faced him

[2] A detaining facility of the juvenile court, also utilized by the treatment center as an extreme measure of control.

with the reality of his bringing on expulsion from school and questioned the continuance of a school program for him ("Why don't you withdraw?"), Marvin would somehow rally and limp along for another period of time. In the last year of high school, at a point when success seemed imminent, Marvin again panicked and threatened to quit. His caseworker told him that he seemed to act as though the world would fall apart were he to succeed and he was like a little boy crying out for something—but what? Marvin began to cry and said, "I don't want to stand on my own feet. I want my mother to take me in her arms, tell me I'm OK and that everything will be all right. But I'm afraid it's too late."

After this expression of feeling, his retreat to the infirmary ceased. By the final semester, Marvin was able to face the completion of his high school education with mounting anxiety but with minimal acting out. On graduation day he allowed himself a success which, for the first time, he did not have to destroy. Shortly thereafter he was discharged from the treatment center, knowing that he had accomplished much by way of inner control, establishing relationships, and achieving some successes. However, both he and the staff recognized that the task of resolving his major conflict around his passivity (which he could only begin to glance at fleetingly) had yet to be tackled, perhaps at some future date in life.

TOM: BACKGROUND

Tom, a 14-year-old, was the offspring of a Protestant mother and a Catholic father, the second child in a family consisting of an 18-year-old sister, 4-year-old half-brother, and a half-sister of 1 year. His parents obtained a civil divorce when he was 2½. Prior to this, Tom had lived with his mother and sister while the father was in service. When the father returned, he made attempts to reunite the family. He accused the mother of having spoiled Tom and entered into a competitive situation with the boy for the mother. At the same time, he showed marked preference for his daughter. His attempts to hold the family together were unsuccessful; the mother insisted on a divorce, and in the face of the father's resistance, literally deserted. The father took the children to another city to live with his mother, while he returned to his job.

When Tom was 5, the father remarried and took the children into his newly established home. Tom did not like leaving his grandmother and let his feelings be known. Once again father and son engaged in a competition for the mother. During the next four years, Tom showed increasing unrest in this situation. At home his behavior became passive and withdrawn. However, there were mounting reports from the school authorities that, although he was of high potential intellect, his behavior was becoming uncontrollable. He hit and kicked other children and was provocative and defiant toward teachers. Because of this behavior, three different public and two parochial schools were tried in this four-year period.

There was no modification of his behavior. The parents reacted to the school reports by not talking to him. The father beat him on receipt of each report. Finally, the board of education demanded that Tom be placed either in a dependency institution for exceptionally bright children or in the state training school.

At the age of 9, he was sent to the dependency institution, remaining there for two and a half years. His adjustment was predominantly poor and eventually the institution's staff recognized that they could no longer handle him. Tom insisted on returning home ("I've learned my lesson") and the parents, because of their own mixed guilt feelings, were unable to deny his request. They were skeptical about his ability to adjust to the home and let him know this. For the first time he began acting out at home rather than in school. In fact, he was able to finish the eighth grade in a vocational school. However, he began to steal

cars and spent several periods of time in the detention home for these activities. Interestingly, the father said nothing about the car stealings, but kept emphasizing Tom's school performance. After a year and a half, when he was 13, he stole his father's car (which he had done several times in the past), crossed the state line, and was apprehended by the police. He was committed to the state training school, but an emergency request for admission to the treatment center was accepted. The court agreed to this as a last alternative, indicating that if this placement proved unsuccessful Tom would be sent to the state training school.

TOM: TREATMENT

Shortly after Tom's placement, he entered into a casework relationship with an almost hysterical frenzy, as if the caseworker were his lifeline. He had been made aware that after the first three weeks of placement the caseworker would be taking a leave of absence of seven weeks in order to be hospitalized. As the time approached for Tom's father's first visit, Tom began to call his caseworker in the hospital, seeking casework on the phone. He cautiously expressed anger that the caseworker was gone when he needed him so desperately. Two days before the father's visit Tom ran off, stole a car, and was picked up by the police and placed in the detention home. The unit supervisor visited Tom during this trying time and attempted to arouse his anxiety by questioning the practicality of his returning to the treatment center, since he showed so little ability to control his acting-out behavior. The court ruled in favor of his returning for further treatment. By then the caseworker had returned, and was immediately confronted by Tom with "It's your fault! You weren't here when I needed you!" As some of his aggression began to be directed to the caseworker, Tom started to stabilize himself in the environment.

This process continued until a year later when, after a first visit home, Tom returned to the treatment center, then ran away, stole a car, and was again placed in the detention home. He again told his caseworker it was his fault, for "letting" the treatment center send him home. When the court ruled for another return to treatment, Tom began to "punish" the caseworker by refusing to keep his appointments for a period of two months. However, once again Tom began to stabilize and he has now been able to build enough inner control to refrain from further acting out in the community. Nevertheless, in periods of anxiety (usually associated with quarterly visits from his father or with school tension) he develops a clear-cut pattern manifested by (1) facial and body tension, (2) scattered verbal demands to be discharged, or to work in the community, or to get a driver's license, or be allowed to work on a car, (3) missing or breaking casework appointments, and (4) sporadic stealing episodes on the campus, and (5) withdrawal from the treatment center school. The environment has had to face Tom consistently with the reality and consequences of his acts (denial of privileges or requiring staff escort when leaving the cottage). As the controls tighten, Tom noticeably relaxes and his symptoms become more repressed. The length of this acting-out pattern has steadily decreased over the past year.

As his ability to internalize has developed, Tom has slowly asked for control, as was recently shown when, after a visit from his father, he requested the unit supervisor to limit him severely to the cottage. This visit was particularly significant, for it marked the first time he had been able to stand up to his father and say, "My life is my own. I won't go to school because you insist. I'll go if I want to and right now I can't." Also for the first time, he withdrew from school and in relatively calm fashion discussed it with his school principal, teacher, and cottage counselors. However, with his caseworker he kept saying, "Why can't I stay in school? I know there's something wrong but I'm afraid to find out." At

this time Tom continues to require outer controls with longer periods of being able to do his own controlling. He is aware of conflicts that manifest themselves in school, of his fear of submission, and of his need to "prove something." Nonetheless, he continues to avoid his feelings of passivity by denial and vacillating between wanting to be a "good" (submissive) boy or a "bad" (rebellious) boy.

IRV: BACKGROUND

Irv, age 15, was the older of two children (sister, age 13). His mother was disappointed at not having a girl and found Irv unmanageable, restless, extremely active, and unrewarding from birth. The father was a passive, dependent "good guy" who was overshadowed by the mother, a dominant, controlling, aggressive woman. He was constantly occupied in his retail dry goods business, which he used as a means of escape from his responsibilities as husband and father. For the first two years the parents viewed Irv as tolerable, but not fulfilling their narcissistic needs. Irv reacted to this implied rejection, especially the mother's, with increasing internal unrest and anxiety. At the birth of his sister his inner turmoil became explosive and he reacted to her presence by an alternation of physical attacks and complete ignoring of her existence, and by demands for attention. The parents consistently compared him to her, saying "Why can't you be like your sister? She is everything you are not!" This "devil-angel" comparison only widened the gap between Irv, his parents, and his sister.

With the onset of school it became apparent that Irv was unable to learn, even though of average intelligence (potentially above average). His hyperactivity was manifested by restlessness and innumerable facial and body tics. He began to hit and kick younger girls and frequently provoked peers to attack him. His aggression toward his sister kept increasing, and his parents always protected her from him. For years the parents denied community and school reports about his behavior. Because of their inability to look at their own responsibility for this situation, they projected blame on to the teachers and authorities. In response to his behavior in the home, Irv's mother vacillated between beating him and using such phrases as "Get out of my life!" "I can't look at you!" "You're killing me!" "I wish you were dead!" and lavishly praising him when he attempted to fulfill her demands. She sporadically overwhelmed him with a shower of kisses and seductive hugs in response to his conforming to her desires that he be a "little gentleman." Irv reacted to this by acting out, as a means of handling his incestuous, aggressive feelings and his inner disgust at being seduced.

When he was 13 Irv, along with another delinquent boy, stole money from the community synagogue. He was also caught threatening other boys with a switchblade knife. When the police called this to the attention of the parents, Irv's father minimized his actions and attempted to bribe the officials by using his good reputation in the community and offering to do business favors for them. To Irv the father then gave the material gifts the boy had demanded, saying, "Now be a good boy and don't aggravate your mother." Eventually the police and court called in the parents and told them that if they did not do something for Irv and themselves, the community would have to take action. The local family agency was asked to evaluate the situation. They found the parents unable to modify their handling of Irv and recommended placement at the treatment center. At the age of 14 Irv was admitted.

IRV: TREATMENT

On arrival at the treatment center, Irv was a mass of facial and body tics. He seemed very muddled and confused, and there was an incoherent quality to his speech. He kept telling everyone what a "tough guy"

he was and related numerous knifings and car-stealing incidents in which he had supposedly engaged. In the first weeks of placement he was plagued by frequent nightmares and would scream "Come and help me!" He developed a strong indifference to his appearance and refused to take showers, also became progressively more withdrawn and isolated from the group. In casework, during the early months, Irv spoke of his fear of being "nuts" and that the treatment center was a "nut house." He also questioned the permissiveness of the setting ("This place is too open"), and was slowly able to speak of his fear of not being able to control his behavior ("I might take a hammer, a crowbar, or a knife and attack kids"). As he talked out some of these feelings, his tics noticeably lessened and he seemed more relaxed. However, before and after parental visits there was marked regression. At such times, his hostility and aggressiveness toward the caseworker increased, with remarks such as, "I can't trust you; you'll shoot off your mouth —you queer, homo, lesbian, nigger!" Along with the direction of this to the caseworker there was observed a pronounced decrease of tension in the environment, manifested by fewer nightmares, more self-control, and what was termed by staff as a "likable quality" in him. Some of his deep inner sadness began to reveal itself. He would tell his caseworker that he feared premature discharge from the treatment center, and then in contrast give the impression to the environment that he was going to be in treatment for a good while.

After six months of treatment, his anger toward his parents came more to the surface and his feelings of aggression were, at times, overwhelming. "I'm so full of hate that it's all going to come out at once," he remarked to the caseworker. When an expected letter from his mother did not arrive, he cried out (for the first time), "—— her, I hope she drops dead! I hope she dies!" In discussing this, he asked, "Why have the adults let me down? You don't care about me if I get into trouble. My own parents don't care about me, so why should you?" After expressing his feeling, Irv ran away, and then the next day returned on his own. He spoke of his feeling of abandonment and rejection with the admission that he was "unwanted" by his parents. Concomitant with this, he expressed a fear of cancer and talked of anticipating punishment "for the wrong things I've done." For the first time he brought out the feeling that his sister was "the favorite" and questioned why he had to come to the treatment center while she remained at home. He frequently queried, "Why does my sister get love and not me?"

After a year and three months of treatment, Irv had shown such encouraging consistent progress that he was permitted to have a first visit home. On his return, four days later, he suffered an extreme recurrence of old symptoms (provoking and hitting girls and verbally attacking Negro staff members). His acting out against the boys in the cottage became so intolerable that it necessitated his being isolated from the group and placed in a special single room in the treatment center infirmary. There he remained for six months. This removal from the group helped him to relax almost immediately. During this period he expressed gratitude to the unit supervisor that this control was set. With the caseworker, he attributed his setback to the fact that his "old feelings" had returned and he feared he was "losing love." He kept insisting that he would not stop acting out, and at one point the caseworker seriously questioned whether the treatment center could help him if it continued. With caution, he spoke of his constant anticipation of attack and rejection, and how he attacked and rejected first. ("I'll drop you before you drop me.") He could then begin to recognize the gratification gained in the acting out ("I like fights and arguments, that's why I invite them"). The caseworker consistently underscored the big price he paid for this acting-out behavior.

After two months of isolation in the in-

firmary, he was slowly prepared by the unit supervisor for beginning contacts with his peers of the cottage. Irv had withdrawn into a world of radio and shortwave (even getting licensed as a shortwave operator). In time, he was helped to include a few other boys in this interest. Hesitantly he began to spend brief periods of time in the cottage (structured by himself and the unit supervisor). Also, a marked improvement in his relationship to girls and staff was observed. Eventually he was moved back to the cottage and made this adjustment with relative ease. From the time of his return from his home visit, he began questioning the continuance of his parents' visits to him. After his removal from the group, it was decided (on his request) that parent visits be halted until further notice.

Irv was not able to contain himself in the treatment center school and from the early weeks of placement had been put on a special work program, supervised on the grounds. His involvement in the program has been sporadic but with signs of increased control and co-operation. He has begun to request a return to an academic program, indicating that the work program is not meeting enough of his needs and that he wants "something more" for himself.

DIAGNOSTIC IMPRESSIONS

In viewing these three cases, definite emerging neurotic patterns can be detected which led the boys to manifest their behavior through delinquency. Marvin, Tom, and Irv, suffering from "family exclusion," [3] reacted to the ego-shattering blows of their families by developing pronounced degrees of narcissism as a means of protecting themselves. In actuality, it is likely that their investment of libido was handicapped from the beginning and they never came out of their narcissistic stages. This narcissism drove them to greater acting out. Their delinquency was an attention-getting device, enabling them to "get back" at their families because—among other reasons—they could never again be in the dependent, infantile, secure state of belonging, nursed and protected by a loving mother. In a sense, Marvin and Irv were seeking through delinquency a means of coping with the stifling, effeminizing yet loving control of their mothers. The pressure put upon them to surpass their fathers was interpreted by them as dangerous. In Tom's case the competitive father evoked the fear that to surpass him would not only be dangerous, but would lead to emotional annihilation.

Frequently these boys sensed the delinquent and incestuous ambivalence of their parents. They were thrown into the conflict of adhering to this ambivalence—failing and getting into trouble, or succeeding (in social tactics, at any rate) in order to gain love. They also projected outside themselves (where the ambivalence was not clearly discernible) the causes of their problems, thus absolving themselves of any guilt or responsibility. Sensing the ambivalence, they needed to act out in order to defend themselves, escaping their own incestuous drives, almost as if saying, "Remove me from this seductive, stimulating, erotic situation."

In a way, these boys were unable to forgive themselves the "original oedipal sin" which prevented them from investing in other human beings. As adolescents they needed the firm, consistent adult—a father to control and protect them—and became angry when adult roles were not fulfilled. Either the adult had been seductive or he allowed the child's own seductiveness to go unchecked. Interpreted by these boys, the "bad" ones (parents) stayed home and they themselves got into trouble, becoming family-excluded. Typically with the neurotic delinquent, they needed to be caught and punished. Among other things, they were testing whether they were still acceptable to their families. As Tom stated: "I paid my debt; take me back home." Whenever he

[3] Bertram Beck, *The Nature of the Delinquency Problem*, proceedings of the institute on "Teamwork for Prevention and Treatment of Juvenile Delinquency," Western Reserve University, Cleveland, Ohio, June 20–24, 1955.

acted out, he justified himself as having done *his* share, while family and community rejected him. Irv, after undergoing changes about himself during treatment, went home for a visit and returned to the center suffering a setback. In discussing his reaction he said, "I made changes but my parents didn't, and if they don't change, why should I?" These were basically family-excluded "leopards trying to change their spots"; the rejection was reactivated when they returned, wanting to fulfill parental-social demands. Re-entry into the home once again ignited the conflict: whether to meet these demands with their penalties—emasculation, loss of self, and restimulated, unspoken, erotic pleasure wishes—or to act out, leading to possible community notoriety and exclusion.

Adelaide M. Johnson says of the same group, "The astonishing observation emerging repeatedly in our studies was the subtle manner in which one child in a family of several children might unconsciously be singled out as the scapegoat to acting out the parent's poorly integrated and forbidden impulses. Analytical study of the significant parent showed unmistakably the peculiar meaning this child had for the parent and the tragic mode in which both the parent and the child were consciously but, much more often *unconsciously,* involved in the fatal march of events." [4]

The ineffectual fathers can use the acting out to be righteous and indignant and yet communicate to the child a satisfaction with the delinquency, thus stimulating him further to please the parent. For example, Tom's father once gave the boy a cigarette and said, "Now don't break into a drugstore just to get cigarettes." In casework, Tom later recognized this interplay and said, "I always felt I was pleasing my father when I would get into trouble." Reinforcing this concept, Robert Lindner has said, "From the unconsciously given clues which parents present to the delinquent in the most subtle and devious of ways, from their scarce concealed encouragement and permissiveness, from their inconsistency—even the dullest child soon comes to apprehend that his parents literally *want* him to rebel." [5]

Giving up attachments to parents left these boys lonely and no longer able to succeed in being children. They reacted to their unacceptable passive identifications; in a sense theirs was a reaction-formation to this passivity. Some delinquents identify with their mother, who, being the aggressive parent, forces them into this identification as a means of protection. They see themselves as potentially annihilated and seek refuge behind their aggressive facades. The fear of annihilation is further supported by the passive father who fails in his protective authority role. As in the cases of Marvin and Irv, to identify with these ineffectual men means emasculation. "In order to keep himself alive, the delinquent refuses to grow up. Because of the physical or emotional separation of the father, the masculine role is believed to end in death or exile. Therefore, no premium is to be gained by growing up into a man." [6] These boys viewed their fathers as failures, which made it convenient to accept failures. Having to learn to be men from these father-images made it easier not to have to compete or take the risk of surpassing. In most of these cases, the mothers reinforce the passivity of the fathers and seduce their sons to be the men their fathers were not capable of being. To quote Marvin, "My father was a knuckle-under guy who my mother could bend in any direction. After all, we two men had to stick together against that damn woman." Having identified with the mother, this type of delinquent perpetuates his self-destructive mechanisms as a payment for the guilt and anger he harbors for not being able to fulfill his male role. Marvin's anxiety increased as he revealed signs of succeeding in school, followed by undoing this, through failure and acting out. "What right do I have to go beyond my father who never

[4] Adelaide M. Johnson, quoted in Robert Lindner, *Prescription for Rebellion* (New York: Rinehart & Co., 1952), pp. 74–75.

[5] Lindner, *ibid.*

[6] G. Pearson, *Conflict of Generations* (New York: W. W. Norton & Co., 1958), p. 99.

finished the ninth grade?" he asked his caseworker. "Besides, my mother always said that I had to go to college and be something —not like my father."

Conformity (school, rules, laws, adult guidance and standards) is often an area of attack to the neurotic delinquent, who views such adherence as sissified, girlish, queer, and so on. It it interesting to note that as Marvin began to succeed in school (during treatment), he anxiously said to his caseworker, "If I succeed in school, I might as well let my hair grow long and paint my fingernails red." Along this theme, Tom insisted he could not go to school since he was not going to be "a perfect angel, half-girl, half-boy!" Such conformity means that he is submitting to his passivity and has proved the very thing he fears—namely, that he is castrated and impotent. To adjust to a society and culture that demands conformity means to this type of delinquent to have resigned himself to a fate worse than death. The price is too great to pay unless he can invest in a healthy relationship, which he has not been able to do. According to Dr. Z. Alexander Aarons, the delinquent "has not been able to make the kind of identifications necessary in order to facilitate the sublimation of his pregenital instinctual drives." [7] Because of their inability to make healthy identifications, these boys anticipated rejection and attack. Therefore they rejected and attacked. They compulsively brought on, by their negativism, the rejection they were supposedly defending themselves from. They acted out in a repetitive, obsessional manner, reinvoking as a response from all sides the primary parental rejection. Failure became their reality, their life pattern. One can almost speculate whether in such cases the need to defeat success is not, in some sense, a fallacy, since success itself is such a fleeting, tenuous part of their personalities. They don't, in reality, know how to succeed.

[7] Z. Alexander Aarons, "Some Problems in Delinquency and Their Treatment by a Casework Agency," *Social Casework*, Vol. 40, No. 5 (May 1959).

In the neurotic delinquent, the conscience is damaged or not adequately developed, resulting in antisocial behavior necessitating external controls. The delinquent cannot submit to his conscience because of the lack of superego development and is therefore unable to abandon his defiance. This is the primary way in which he protects himself. In another sense, during acting-out episodes, the delinquent anesthetizes his shaky superego, which represents the incorporated parent figures. He attacks the parents by attacking his conscience.[8] Furthermore, since the parents give conscious verbalized credence to conformity, he escapes into a quasi-freedom from this because of his inability to identify with them. According to Josselyn,

> the character formation of the adolescent is not structurized, but is still fluid. He acts out his defiance of his conscience in order to have a sense of freedom from it. In the delinquent, his goal is often to gain punishment. The normal adolescent is frightened by his freedom, and he abandons his defiance and submits to his conscience. The conscience then behaves as parents behave when they punish a child for an act committed in their absence. Once the conscience is back in control, external punishment is sought or self-punishment is administered.[9]

The opposite is true of the neurotic delinquent as he periodically immobilizes his guilt-producing mechanism.

CONCLUSION

In treating these three neurotic delinquents in a treatment center, it was the role of the unit supervisor to modify reality according to the needs of the individual child, to supervise cottage counselors in their roles of nonpunitive authority, and to implement each child's treatment plan. The unit supervisor was also, in a sense, the child's superego. On the other hand, the case-

[8] K. Menninger, *Man Against Himself* (New York: Harcourt, Brace & Co., 1958), pp. 224–226.

[9] I. Josselyn, *The Adolescent and His World* (New York: Family Service Association of America, 1952), p. 70.

worker's role as a therapist was to identify with the children's feelings, to support their shaky egos as much as possible, and to help them gain insight as to how they were reacting to the environment. In addition, the caseworker helped them to handle their feelings in more socially acceptable ways.

The most difficult task was to provide the necessary firm but understanding outer controls to halt their acting out. This was slowly incorporated by the boys, thus enhancing the development of their inner controls. As they were consistently confronted with their antisocial behavior, they began to internalize some of their anxiety. As inner turmoil and conflict mounted, psychosomatic symptoms appeared. In all three cases, during periods of extreme stress it was observed that the boys retreated to the infirmary with complaints of sore throats, backaches, headaches, and other vague symptoms. As internalization progressed, the anxiety became directed toward the caseworker and the environmental staff. A barrage of hostility, insatiable demands, verbal attacks, threats of acting out, and minor delinquent acts were projected onto the most meaningful relationships. The basic knowledge that retaliation and counteraggression on the part of the trusted adult were not in the picture had a most therapeutic effect, providing a sense of security hitherto unknown to the child. A freeing process slowly unfolded, and functioning in such ego-building areas as school, athletics, relationships (peers and adults), and creative activities began to appear. These boys started to build on a series of small successes heightening their sense of self-worth. The self-image of being a damaged, broken person began to take on an aspect of becoming "someone"; the healthy concept of "I" was initiated.

As these changes came about, a process of identification with the trusted adult grew. They viewed themselves as giving up their delinquent pattern for the adult. As Tom once said to his caseworker, "I'm doing this for you, so don't you ever forget it." To be able to do this for himself is the ultimate goal. With the building of inner controls, these boys have become aware that by giving up they have gained. Initially they challenged the implied reward of love and acceptance because of their fear of being left with nothing. Along with increasing tolerance for frustration and increased ability to relate came the ability to cope with anxiety. These new-found strengths were continually tested, and they needed to know that they could be controlled yet accepted for themselves.

Through support, and recognition of his unhappiness during this period of transition, the child can take beginning glances at his past and the realities of his life. He is able finally to pinpoint his anger at his parents, by whom he has felt misunderstood and rejected. In time he can give up the god-images he has made of them and they slowly become to him human beings with problems of their own. His need to strike back and destroy them (by destroying himself), for what he feels was done to him, diminishes. Instead, a quiet tolerance of the mistakes of the past replaces the anger, hurt, and disappointment. Most of all, he gains recognition of the fact that he himself can be restored to human value and wholeness.

In conclusion, the adult—whether in the community or a member of the treatment team—must develop a sense of self-integrity which is a kind of therapeutic mirror, reflecting in useful and understanding ways what the neurotic delinquent is, what he does, and what he can do. The adult has to make available to him the healthy identification that has been unknown and unattainable. In effect, he supplies the "cast" for the "fractured ego." In spite of these efforts, it remains for the child, depending on his ego capacity, to make changes for himself at his own level. The child will engage in a seemingly unending struggle before giving up, if ever, any part of his illness. However, because of his basic infantile needs and desires, it is to be hoped that the adult world can patiently guide him toward health, instilling into him the necessary incentives for mature adulthood.

BY EILEEN S. CASSIDY AND MARGARET M. BULLARD

The California Story

THE WRITERS, AS well as many other social workers in California, have been concerned with the methods used by social workers in seeking legal regulation in California. We believe that "how the past perishes is how the future becomes." [1] In order to extract some essence of experience which may contribute to "how the future becomes" in legal regulation, the following summary is submitted of the California story.

As long as forty-five years ago, Abraham Flexner was asking the same question that was being asked last year in California during the discussion of the legal regulation bill. At the 1915 Conference of Charities and Corrections, he queried, "Is social work a profession?" [2] Chief among the Californians who last year questioned whether social work was a profession ready for legal regulation were certain members of NASW.

In the summer of 1959, the *Newsletter* of the Board of Social Work Examiners of the California Department of Professional and Vocational Standards made a similar point. "It is certain that social workers, whether professionally qualified or not and in whatever of the many varying fields of social work, must thoroughly support any licensing bill if it is to be passed. Unfortunately, there are still some people who do not recognize the importance of professional status for social workers. When social workers themselves do not agree and indicate a split in their ranks, the beliefs of this group are confirmed." [3]

Social workers, since the beginning of their professional activity, have taken steps in a variety of ways toward the development of legal regulation for the profession. The California history of legal regulation has paralleled, if not preceded, the experience on the national scene. Readers of this journal are well acquainted with the current steps proposed by the National Association of Social Workers on the regulation of social work practice.[4] The February 1960 issue of *NASW News* gives the immediate goal as that of "title protection" and the long-term goal as that of "restrictive regulation of practice." Legal regulation has been the consistent goal of the profession.

EARLY DEVELOPMENT

"Efforts to register social workers have been made from time to time. In California, the first recorded discussion of licensing social workers was noted in 1920 when a group of workers held a meeting to discuss the possibility of restricting practice in the public services to persons with certain minimum qualifications." [5] Californians early

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[1] Alfred North Whitehead, *Adventures of Ideas* (New York: Macmillan Co., 1925)—also published as a Mentor Book.

[2] *Proceedings of the Forty-second National Conference of Charities and Corrections,* Baltimore, Maryland, 1915 (Chicago. Hildmann Printing Co., 1915), p. 516.

[3] Summer *Newsletter,* 1959.

[4] *NASW News,* Vol. 5, No. 2 (February 1960), pp. 14–23.

[5] R. E. Arne, "Protection of the Public Through Licensing of Social Workers," *Social Work Journal,* Vol. 33, No. 4 (October 1952), pp. 187–188.

supported movement toward legal regulation with the introduction of a bill in 1929 by the League of Women Voters and the California Conference of Social Workers (now California Association of Health and Welfare). Although the legislation was defeated, a voluntary registration system was established under the auspices of the California Conference of Social Work. After several unsuccessful presentations to the legislature, essentially the same system became law in 1945. The enactment of this legislation (Chapter 17 of the Business and Professions Code relating to social workers) created a Board of Social Work Examiners for registering social workers qualifying under the terms of the act.

Certain guides for future action were suggested by the executive director of the Board of Social Work Examiners as follows:

> First, there should be active and intelligent support for a licensing law by professional organizations and lay groups. A united front should be presented to the legislature, especially by all social workers.
>
> Second, any initial licensure law will require a "grandfather clause" or waiver to make it possible for experienced persons on the job to be licensed. No legislature would consider passing a law which would exclude members of a profession who were already engaged in that profession within the state. It might be possible to establish categories in such a way that a majority would be required to take a written examination. Of the 4,000 initial registrations [1945] in California about 2,500 had actually passed a written examination.
>
> Third, the restriction of practice (after the blanketing-in period) might be accomplished by the adoption of one of the following plans:
>
> License two categories such as "social workers" and "social work technicians." This would follow the pattern found in laws licensing dentists and dental hygienists. Some of the laws define the functions of the hygienist and specify where she may practice.
>
> Restrict the use of the term "social worker" to licensed practitioners. This would correspond to some laws relating to architects. An individual can draw plans for a house, sell the plans, and supervise construction, but it is illegal for such a person to pose as an architect.
>
> Limit practice to those who pass an examination given by a board. Depend on the examination to weed out the unqualified and those with a limited education. The educational qualifications can then be increased gradually. This plan follows the pattern of the legal profession.
>
> License all social workers by classifications. This is common in the engineering field. While all engineers have some basic equipment in common, they take examinations and are classified as chemical engineers, civil engineers, electrical engineers, and so forth. The boards of engineer examiners usually also license land surveyors, and in recent years have added the "engineer-in-training." [6]

However, these suggestions were not pursued by California social workers. A relatively dormant period followed. The initial spurt of registration under the 1945 law leveled off to a plateau during the ensuing eleven years. During this time the Los Angeles County Merit System introduced use of the title *Registered Social Worker* as an element for advancement in their classification system. In San Diego an ordinance was passed requiring a license of all nonmedical persons engaged in private counseling or psychotherapy.

INQUIRY BY SENATE COMMITTEE

For two years prior to 1957, an interim committee of the state senate examined the various licensing, registration, and accreditation boards existing in the state of California. As a result of its deliberations, the committee recommended to the 1957 legislature that one of the twenty-six groups given legal regulation under the Business and Professions Code in the state be eliminated. The group singled out was the Board of Social

[6] *Ibid.*, p. 190.

Work Examiners. Discussion with members of the legislature indicated that two main factors influenced the recommendation.

1. The apathy of the social work profession in not giving further attention and nurture to the law which they had urged be written into the code in 1945. The profession then had intimated that efforts would be made to extend the registration of social workers.

2. The concern of some members of the legislature over the paradox that licensing restrictions, while protecting the public, might concurrently be laying a foundation for inhibiting competition.[7]

Senate Bill 172,[8] proposing to repeal the voluntary registration legislation, was introduced January 9, 1957. While social workers could not agree with the proposal to abolish the voluntary registration program, they were indebted to the senate interim committee for focusing attention on the necessity for improvement. Workers throughout the state, reacting to this attack on their registration law, rallied to its defense and a countermeasure, Senate Bill 975, was introduced January 21, 1957, at the behest of the California Association for Health and Welfare. This measure proposed to preserve and strengthen the existing law. It added to the statement of purpose in the existing law the phrase "to *register* and *classify* those persons who are engaged in public and private welfare agencies in providing social service," and authorized the board to establish "a *system of classification* which will lead to the ultimate qualification of those persons now engaged by public and private social agencies in carrying out the responsibilities of such agencies." [9]

Upon the request of the social workers, the legislature referred both bills to the senate interim committee for study and recommended action to the 1959 legislature. The Board of Social Work Examiners was thus committed, in effect, to canvass the profession, suggest proposals for changes strengthening Chapter 17 of the Business and Professions Code, and provide more effective protection to the public. A statewide advisory committee to the board was developed to recommend a program.

CALIFORNIA COUNCIL OF NASW CHAPTERS

The California Council of NASW Chapters was born in 1956 to meet the pressing need for a vehicle through which to speak for the profession throughout the state.[10] One of its first acts was to face the fact that the recognition given the profession through the law registering social workers was in jeopardy.[11]

On February 2, 1957, at the first meeting of the California Council of NASW Chapters an *ad hoc* committee was established, charged with the responsibility of doing everything possible to defeat S.B. 172, the measure for repeal. Permission was given to support S.B. 975, strengthening the existing law, but the consensus was that more work needed to be done before a classification system for registering social workers could be fully supported. The committee recommended that each chapter set up special study committees to explore implications of legal regulation of practice and educational content for varying levels. A strategy committee of the state council was formed to take initiative in planning a joint committee with the California Social Workers Organization and the California Asso-

[7] For further elaboration of this concept, *see* the discussion on the nature of the problem as spelled out in *Occupational Licensing in the States* (Chicago: Council of State Governments, 1952).

[8] Hereafter referred to as S.B. 172.

[9] Summer *Newsletter*, 1958, Board of Social Work Examiners, Department of Professional and Vocational Standards, Sacramento, California. (Emphasis supplied, to mark the first reference to classifications in proposed legislation.)

[10] The state council was composed of delegates appointed or elected by the eleven (now thirteen) chapters in California. There is one delegate for each 500 members of a chapter.

[11] Under the leadership of state council president Margaret H. Mudgett and legislative chairman Esther Elder Smith.

ciation for Health and Welfare, the two other state-wide organizations, in providing study and support of legal regulation. The council asked the Los Angeles chapter to assume responsibility for a more detailed study of legal regulation and to work with other chapters in the state toward a set of principles in regard to legal regulation. At the same time, a council committee was established to guide the work of chapters and take leadership in implementing legal regulation. Throughout the year there was study and consultation with practitioners, administrators, and the Board of Social Work Examiners. Study material was fed to the chapters continuously through the committee structure.

Delegates at the council meeting on December 7, 1957, accepted the report of the council's committee on legal regulation and adopted the following position: "The California Council of NASW Chapters supports the goal of mandatory licensing for the practice of social work. The State Council recommends all sound steps toward the achievement of that goal." [12] The state council adopted a set of fundamental principles which were followed throughout the subsequent legislation on a licensing bill. These were:

1. That the professional classification must be related to educational preparation and that experience cannot be substituted. Since the base of a profession is an educational discipline, the acceptance of such a substitution would negate the claim of social work to professional status.

2. That the titles must be as nearly self-evident to the public as possible to achieve, and must differentiate those persons who have greater preparation from those who have less.

3. That the classifications must be as few in number as possible and reflect as clearly as possible varying degrees of preparation.

By July 1958, the council position statement had been ratified by each of the eleven chapters.

[12] Minutes of the Delegate Meeting, December 7, 1957, California Council of NASW Chapters, Monterey, California (in the files of the council).

SOME PROPOSALS, THEN A BILL

In August 1958, the first draft of a legislative bill amending the existing law was made by the Board of Social Work Examiners. This proposed to incorporate into the current law provisions for registering, classifying, and licensing all social workers under three categories—*Graduate Social Worker, Registered Social Worker,* and *Associate Social Worker;* also for developing and providing sources of information for research; establishing a board consisting of seven appointed members of whom three would be graduate social workers, two registered social workers, and two lay members; restricting use of the title *Social Worker* under license; and for reciprocity with other states and minimum qualification of a bachelor's degree for the lowest category. Because of the necessity to amend the existing law, items such as sources of revenue, terms of office of the board, and suspension and revocation of license remained as written in the 1945 law.

Following a state-wide distribution of the proposed bill, suggestions were solicited by the Board of Social Work Examiners. The board held open meetings in strategic geographic locations throughout the state, for the same purpose. Also throughout the state, members of the registered social workers' program and individual social workers, through their professional organizations and employing agencies, were given information regarding these meetings and encouraged to appear and present their viewpoint to the Board of Social Work Examiners. The poor attendance of professional social workers at these meetings caused the chairman of that board to express disappointment in the apparent lack of interest of the professional membership at this important stage of development in legal regulation.

The recommendations of the senate interim committee, which had been studying

the bill, were made public early in January 1959. These were:

1. That no mandatory licensing be required of social workers employed in any governmental agency.

2. That the committee would not oppose further consideration by the legislature of mandatory licensing to establish one statewide minimal level of education and/or experience for employment as a social worker in private profit and nonprofit agencies.[13]

In California, two-thirds to three-fourths of the social workers are employed in governmental agencies. For some social workers, the interim committee's recommendations underscored the statement in the British Association of Social Workers' report, which had pointed out with respect to registration "the danger of waiting too long until the initiative passes into other hands, as frequently happens once the State becomes the largest employer." [14]

In January 1959, Assembly Bill 244,[15] providing for mandatory licensing of social workers and restricting use of the title, was introduced in the legislature for the Board of Social Work Examiners. The bill incorporated changes suggested by members of the profession and the state council, one of which was changing the name of the top category from *Graduate Social Worker* to *Certified Social Worker*. Other significant changes were made in the assembly social welfare committee. These were:

1. An automatic substitution of successful completion of a social work examination in a governmental merit system or civil service jurisdiction for an A.B. degree in the last category.

2. An extension of the time for the blanketing-in provision.

3. Modification in the conditions for revoking a license.

However, the bill was not brought to a final vote. It moved with relative rapidity through the various legislative steps, in a session filled with vital and far-reaching policy legislation proposed by the newly inaugurated Democratic administration.

Action was as follows:

January 14, 1959: Introduced in the Assembly by Mr. Byron Rumford, Miss Donahoe, Messrs. Crawford, Luckel, Hegland, Kennick, Schrade.

Amended in Assembly: March 20, April 3, April 17, and May 6, 1959.

Amended in Senate: May 19, 1959.

April 16, 1959: Passed Assembly Social Welfare Committee unanimously.

May 1, 1959: Passed Assembly Ways and Means Committee unanimously.

May 7, 1959: Passed Assembly—72 for, 1 against.

May 12, 1959: Passed Senate Business and Professions Committee by unanimous vote.

May 18, 1959: Passed Senate Finance Committee—6 for, 1 against.

June 6, 1959: Referred for interim study —19 for, 18 against.[16]

The council considered the bill a step forward in achieving legal regulation. In addition to restricting titles, it required registration of every person in a social work position, public, private, and self-employed. It provided to the public, to the individual, and to the profession an identification of the social worker's educational preparation for the position held (see p. 57). This, in turn, would give the public a means for evaluating the educational qualifications of the social work staff of an agency. It would provide incentive for persons in the field to move from one category to another, higher category. It specifically pointed toward the utilization of research projects for the development of professional social work standards and potentially would make available a body of knowledge, currently nonexistent, about those engaged in the practice of social work. (The 1960 census of social work will provide some information about social

[13] Senate Interim Committee on Social Welfare, *Licensing of Social Workers* (Sacramento, Calif.: Senate of the State of California, 1959).

[14] *A Report on Registration and the Social Worker* (Slough, England: British Association of Social Work of Great Britain, 1955).

[15] Hereafter referred to as A.B. 244.

[16] Excerpts from council report to chapter chairmen and delegates, June 12, 1959.

workers, and every ten years the census will give a point-in-time source of information. However, the census type of information lacks continuous, dynamic facts vital to our understanding of our profession in relation to other occupations.) The bill set an educational floor of a master's degree from an accredited school of social work and other prerequisites to be established by the Board of Social Work Examiners for those self-employed in private practice.

UNCERTAINTY AND OPPOSITION

Delay and postponement before the senate committee, coupled with the practical impossibility of informing the membership of rapid amendments and changes, made for confusion. Once a policy is set and the legislative process begun, such communication is frequently impossible.[17] Some NASW members had expected a bill defining practice rather than a title-restriction bill, and were opposed to legal regulation without a definition of practice. Confusion may also have been created by misinterpreting the discussion of the voluntary certification plan by national NASW as being a substitute for legal regulation.[18] Members may not have read the statement that "California . . . may undoubtedly wish to continue its efforts to strengthen and improve . . . their existing statutes concerning legal regulation of social work."[19] The re-examination of education made by the advisory committee to the Liaison Committee for Higher Education in California, as well as the Curriculum Study of the Council on Social Work Education, created apprehension among some members who felt that it was not timely to establish legal regulation based on educational attainments.

Under the auspices of the State Department of Social Welfare, a series of committees considering the recruitment, training, and utilization of social workers presented recommendations, some of which related to a classification of social workers by educational preparation. These classifications were based on concepts similar to those expressed in A.B. 244, but had differing categories, which led to confusion in the minds of some.

Some social workers recalled the 1955 recommendations of a group which had been studying the needs of California in higher education.[20] The recommendations were that the State Department of Social Welfare should be designated to administer the regulation of social work. There were those who believed that the Department of Social Welfare should have a position in respect to the licensing of social workers similar to that held by the Department of Education in respect to teacher accreditation. Other social workers were equally convinced that a separate agency, concerned with the total profession and more directly responsible to the membership itself, was a more appropriate way of providing legal regulation for social work.

Although certain weakening changes had been made in the bill between initiation in the assembly and final passage from the assembly on May 7, 1959,[21] its legislative authors urged that the measure be passed on to the senate without further delay by amendment. The senator shepherding the measure through the senate had agreed that when it came on the floor for final discussion he would propose reinstatement of the minimum educational floor and a qualifying adjective before the title of the beginning category. The council was faced with two alternatives: to request withdrawal of the bill if it appeared without an educational base, or to continue to support the

[17] Even the legislative authors of the bill were unable, at times—because of the slowdown of printing—to be certain of the text of the most recent reading of the bill.

[18] Note that subsequent to the presentation of the National Certification Plan it was learned that this plan is itself related to a federal statute. *See NASW News*, Vol. 5, No. 3 (May 1960), p. 2.

[19] *NASW News*, Vol. 4, No. 2 (February 1959), p. 26.

[20] *A Restudy of the Needs of California in Higher Education* (Sacramento, Calif.: California State Department of Education, 1955).

[21] *See* changes listed on p. 60, col. 1.

bill and arrange to amend it at a subsequent session.

FACTORS IMPEDING PASSAGE

Chapters had been submitting thoughtful well-constructed arguments to legislators in response to council requests for chapter support at strategic moments during the bill's progress through the assembly. There is little question that the unity of NASW chapters was responsible for the complimentary statements of various assemblymen regarding the social work profession and the successful passage of the bill through the lower house on May 7, 1959.

On May 11 one of the larger chapters withdrew its support of A.B. 244 on grounds that the bill had been weakened by amendments, and requested that it be referred to an interim committee for further study.[22] Two other chapters raised questions on certain sections of the bill. The council continued to support the bill, with the expectation of planned amendments on the floor of the senate, until the final action on June 9, when it was referred for interim study. Subsequently, two more chapters officially informed the council of their reservations about the bill.

There was misinformation and apparent distortion of fact about the legislation in reports by some individuals. Prior to any change in chapter positions, individual members in certain sections of the state formed self-appointed *ad hoc* committees to work toward defeat of the bill.[23] The question of the council's final decision on the plan never became actual, because of steps taken by individual members who did not wait for a call for legislative action, which would have been forthcoming. They proceeded on their own, uninformed of the council's plans. The step-by-step strategy of legislative procedure cannot be conveyed readily to a large membership, for the reason that its details must be continually modified to meet the quickly changing scene and temper.

Before the bill had left the first senate committee and was still to be heard by the second senate committee, a number of individual NASW members had wired the governor asking that he veto A.B. 244—a bill which never reached his desk. The unfamiliarity of social workers with the legislative process, combined with the lack of understanding of the possibility of further amendment on the senate floor, contributed to the plethora of individual communications. Possibly individual members were not aware of their own chapter positions when they took their own initiative. Because of changing attendance at chapter meetings, all were not fully acquainted with their chapter positions or familiar with the appropriate chapter procedures for changing them. Formal chapter action often takes more time than independent action, but gives opportunity for consideration of more ideas and for verification of facts.

Traditionally, the senate is considered a more conservative body and less favorably disposed than the assembly toward social work and matters advocated by social workers. It is the authors' belief that any legislative group, besieged by the volume of conflicting points of view expressed in communications from social workers opposing and supporting this bill, would have voted against it—or, at the very best, if favorably inclined toward social workers, would refer it for further study, as was done. Legislators had received the official position statements of the NASW chapters. The volume of adverse communications from individuals identifying themselves as mem-

[22] This was the first and only official action of withdrawal of support by a chapter. Chapters had communicated concern about various aspects of the bill, which the council was endeavoring to keep in mind during the legislative action.

[23] At a special meeting of state council delegates on January 31, 1959, chapter delegates supported the substance of A.B. 244, with one abstaining vote. Another chapter—not represented—voiced objections by wire to the blanketing-in procedures. Minutes of Delegate Meeting, January 31, 1959, California Council of NASW Chapters, Sacramento, California (in the files of the council).

bers of NASW raised some doubt as to the unity of purpose of NASW as an organization.

CURRENT STATUS

On June 14, 1959, after the legislative session had ended, the state council of chapters held a delegate meeting. The group authorized the council to request each chapter to study A.B. 244 in terms of the issues involved and in regard to suggested changes toward a desirable future bill. A council committee has analyzed the assembled data returned by the chapters and has made council recommendations which will go back to the chapters for their evaluation and reaction. Hearings of the Senate Interim Committee on Business and Commerce, to which the bill was referred, are to be held prior to the 1961 legislative session. By the time of these hearings, NASW is expected to take a position.

The Board of Social Work Examiners has been restudying legal regulation and has requested the thinking of the NASW membership. The board itself has tentatively proposed changes in A.B. 244, in an effort to meet some of the objections voiced during the 1959 legislative session by some factions in the chapters as well as to strengthen the bill.

The writers, along with many other NASW members, are convinced that there is validity in legal regulation. We further believe that, with unified study and support, a legal regulation bill restricting title can be made into law, possibly as early as the next legislative session. Despite the cloud cast on the emerging public image of social work in the minds of California legislators, and the failure of passage of A.B. 244, we believe that legal regulation is inevitable. It is quite possible that if the social work profession does not take the initiative in developing it, some other group may do so.

There are about 13,000 persons employed as social workers in California at present. Approximately 2,600 of these hold a master's degree in social work.[24] The ratio here is probably similar in other states. The current changing needs of people and communities point up an increasing demand for social services and for manpower to do the job. We do not believe that social work as a profession can at this stage of its development neglect to recognize the majority of workers in the field who are without the desirable professional education. Considered across the nation, our facilities for training are limited and need expansion. Current facilities produce few more graduates than the number needed to replenish natural attrition in the field.

Just as the profession is proceeding to define for itself the indispensable professional core of social work and levels of practice, so must another step toward long-range development be taken through legal regulation. By the same token, legal regulation must make a beginning. In time, there will be clarification sufficient for the incorporation of a definition of practice in a legal regulation bill.

An urgent need for legal regulation of social work is implicit in many recent developments, an important one of which is the rapid growth of private practice of social work on a fee basis. Regulation by law is imperative to provide a legal foundation on which these social workers can function, and to avoid finding ourselves in competition with charlatans.

Insufficient attention has been given to the research aspects—the fact-gathering possibilities—inherent in mandatory licensing. An increasingly important body of facts about social workers and social work would accumulate under a mandatory licensing law. Such facts would have many uses.[25]

[24] Estimates made in 1960 by California Department of Social Welfare and the state NASW council.

[25] A recent request to the profession from the California Governor's Committee on Medical Aid and Health to provide data on its current numbers, needs, and projected needs could not be answered, precisely for lack of a central point of registration.

REMOVING THE ROADBLOCKS TO LEGAL REGULATION

1. *Clarification of steps in regulation of practice.* It is important to differentiate legal regulation from the National Certification Plan and the diplomate plan. These programs are not in conflict, but are indeed natural complements to provide a supportive framework and recognition to the profession. The National Certification Plan will accord the professionally trained worker the privilege of using the initials ACSW after his name and will indicate a level of training and experience as a professional social worker. The diplomate program will single out those with special skill and training for greater recognition. Supporting a certification and diplomate program, there must be a foundation of legal regulation encompassing all social work service, differentiating levels of education. Such a base is not in conflict with NASW policy.

2. *Professional unity and readiness.* Divided opinion on specific issues within groups is an expected and desired occurrence. However, the extent of division and degree of emotionalism generated on the issue of legal regulation in California seemed out of proportion to the issue itself. It is important that the thinking of the profession remain clear as to purpose to be achieved, since division of opinion and feeling is lessened when the focus is kept on the long-range goals rather than immediate protection for those of us now possessing a master's degree.

Reference has been made in this paper to the question of the readiness of social workers for a beginning type of regulation. The answer appears to lie in a consideration of the readiness of the profession, based on current realities, rather than a mere aggregate readiness of certain groups of individuals.

3. *Familiarity with legislative processes.* In seeking legislation, a knowledge of process and method is as important as in other specialized activity. It is important to understand this process and method as the practicality with which we must work when attempting to influence legislation. The principles of our representative government must also be understood. The legislators who hold the ultimate power for lawmaking are responsible, under democratic government, to the whole people. NASW as one group has an opportunity to express itself, through its delegated authority, to the legislators. When various groups are in conflict, the only sound resolution is in compromise, the essence of legislation.

4. *Resources to do the job.* A resource often mentioned would be money to purchase the services of a legislative advocate. While the aid of a legislative advocate could be productive, the resources already at our disposal should not be overlooked. Within our ranks are responsible delegates, appointed or elected—members with experience and competence in dealing with legislative processes. Understanding and sympathetic legislators who have confidence in social workers are another resource. Other organizations are often interested in social work legislative proposals and can be helpful. A state council is an instrument through which to work. For example, the California State Council worked with limited funds, and the accomplishment of seeing action through both houses of the legislature was achieved by social workers holding full-time jobs.

5. *Delegated authority.* Any group seeking to accomplish legislative ends needs to delegate—within policy guides—authority to those who will seek the actual passage of the legislation. The lack of clarity on this point was certainly an underlying issue in the California experience. Some NASW members questioned the source of the state council's authority in relation to legislative activity. The question is not so much the basis of authority, but whether the chapters are willing to delegate a portion of their authority. For clearly the basis of the council's authority derives from the individ-

ual chapters that appoint or elect delegates to it.

There is a direct relationship between the maturity of the profession and its capacity to unify and pyramid its leadership. Pyramiding authority is contrary to the practice of social casework, but this is not true in social action.

6. *Proper legislative climate.* Since practically all legislation comes about through compromise, the legislative climate is extremely important. Concerted and unified effort actually was able to reverse completely the earlier negative viewpoints expressed by the senate interim committees, so that a genuine friendliness toward the profession was created. The tempo of the legislative process, however, requires that such a climate be maintained. This was not possible when, very late in the legislative session, division appeared within the ranks of social work. Despite this setback, many legislators came to know social work better and are ready to help if we can clarify our own purposes.

California, for many historical reasons, is approaching the matter of legal regulation at the point of title restriction. Other states may be able to obtain laws beginning at another point. Each state will, no doubt, determine for itself the method of legal regulation most appropriate to its own needs, based on its previous experience with regulation for social work and other professions, and in relation to its own political climate.

Our experience has demonstrated the need for unified leadership from the social work profession. We share this experience for whatever value it may have for the profession as a whole.

BY ARNOLD J. AUERBACH

Aspirations of Power People and Agency Goals

TWO IMPORTANT MOTIVATING factors attract lay persons to our agencies. One is the obvious satisfaction of being identified with a social cause and the ability to make a positive contribution to the community. The other—less frequently discussed—is the element of recognition, prestige, and power gained through community activity.

Many social workers have regarded the latter as a negative inducement, or have denied its importance, or at best accepted it as a necessary evil. In so doing, however, they fail to realize that this striving for status and recognition not only encourages and fosters voluntary community participation, but without it the social goals and objectives of our agencies would be more difficult, if not impossible, to attain.

It is the aim of this paper to examine the aspirations of lay leaders, especially those whom one may characterize as power people, in relation to the social goals of our agencies, and to suggest several approaches to handling and directing the satisfaction of power needs in a positive channel. In so doing, there is danger of appearing overcritical, cynical, or unconstructive; it should be said at once that a conscious effort has been made to avoid giving that impression —without, however, blunting the sharpness of relevant observations.

The social objectives of community agencies committed to the social group work method are clearly and forthrightly expressed in their bylaws, their house organs, and in the annual reports of their presidents and executive directors. The phraseology may differ, but the content is the same. The group service agency exists to "foster the social adjustment of individuals through group associations," or to "promote personal growth according to the individual's capacity and need," or to "foster responsible citizenship and mutual understanding"; or perhaps to "combat juvenile delinquency," or "encourage the qualities of social leadership," and so on. If the agency has a sectarian purpose, this is usually mentioned as one of its primary goals: to promote Christian fellowship, or Jewish identification, or the like.

In all public pronouncements, and in meetings of boards of directors and staff, the theme of democratic values and socially desirable purposes runs like a thread through discussions and controversies, large or small. Sometimes the true meaning of the goals of the agency, and especially the implications of these goals in terms of program and practices, becomes lost in the realities of budgets, personnel practices, building improvements, public relations, membership policies, and programing. But challenge the most uninformed supporter of any of the group service agencies and he will tell you what a wonderful job "we" are doing to develop personality, build character, or—at the very least—"keep the kids off the street."

The continual restatement of the social objectives of an agency is an important factor in attracting the right kind of citizens to the board. It gives them the feeling that they are investing their time and energy in socially approved and worth-while endeavors. It makes them aware that they "belong" to an important institution. It helps them develop a sense of *noblesse*

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oblige—the nearest thing to the psychological status of Lord or Lady Bountiful in our modern industrial civilization.

MOTIVATIONS OF BOARD MEMBERS

All this is undoubtedly true. But one may well wonder whether the appeal of participation in an important and worth-while cause in our agencies does not bear some resemblance to the attraction of our "over-40 clubs" to single men and women. The publicity suggests that these clubs exist for informal good fellowship; no one dares openly breathe the possibility that the lonely participants are desperately searching for a mate. In the case of our board members, may we not perhaps say that many accept board affiliation not only because they are committed to the agency's social goals, but because they are also searching for such "unmentionable" values as status, community recognition, social influence, business contacts—or just a safe escape from a nagging wife or a dull husband? Such motivations are either ignored or, at most, vaguely hinted at in the textbooks, articles, institutes, and manuals available to either board people or professionals.

Perhaps a lay leader can afford to be a little more frank about power, prestige, and status as motivating factors in seeking and attracting board membership. Gustave Heller's article comes to mind, on "The Care and Feeding of Community Leaders."

"To be representative and to command respect," he says, "we know that we must attract to our cause as sponsors and advocates certain people who bring financial strength and the prestige with which such financial strength is usually associated, sometimes without merit." Mr. Heller points out that some of our boards are

> . . . overloaded with husband-wife teams, or are ingrown in another way by the inclusion of a charmed circle of close friends or have become exclusive clubs consisting of tried but tired people whom the executive director feels comfortable with and with whom he believes his job is safe. Or boards of well-meaning people who cannot face a deficit with either courage or hope, but even worse, boards of absentee tycoons who can always be relied on to raise money without knowing or caring much about the purposes for which the money is needed, nor much disposition to share their time and talents with people of lesser financial substance in an effort to find out.[1]

Aileen D. Ross in her study of a Canadian Protestant community entitled "Philanthropic Activity and the Business Career" finds that

> . . . philanthropy, most particularly the organization of financial campaigns, is a substantial activity of successful business men. Such activity is not a matter of "noblesse oblige" or spirit of community responsibility but rather of facilitating business careers, and maintaining good corporation public relations. Business men have community service careers as well as business careers and for each rung on the business ladder there is a rung on the philanthropic ladder and a man has to show his mettle on the latter to qualify for achievement on the former.[2]

Nor are "social welfare careers" confined to businessmen. Lawyers, doctors, insurance agents, and other professionals—and especially housewives—conduct a veritable Mardi Gras in volunteer organization and social agency activity, many of them reaching ever upward toward the next rung on the ladder. One has only to glance through the newspapers or publications, or attend the meetings, of any of the multitude of voluntary agency activities from the united funds down, in any of our cities, to be immediately struck by the immense traffic in pictures, prizes, and praises. The unwary onlooker, forgetting the agencies and agency

[1] Gustave T. Heller, "The Care and Feeding of Community Leaders," *J.W.B. Circle*, Vol. 8, No. 1 (January 1958), p. 8.

[2] Aileen D. Ross, "Philanthropic Activity and Business Career," *Social Forces*, Vol. 32 (March 1954), pp. 274–280.

objectives that are social in nature, might be tempted to believe that perhaps the only reason for all this activity is to give and receive recognition and status.

This is, of course, not so. The need for status and prestige obviously exists; we know there are more wasteful, less socially desirable ways of satisfying it. We cannot criticize people for seeking to fulfill a social need; only if by so doing they channel their drives into antisocial, destructive, or useless pursuits. As far as our board members and lay leadership are concerned, one can have only the greatest admiration and commendation for the fact that, despite the realities of dog-eat-dog competition, shoddy social values, and the insecurities and vicissitudes of modern life, they have chosen an outlet so identified with positive social values and democratic norms.

It is undoubtedly true that very few board members become active in our agencies solely for purposes of prestige, power, or self-aggrandizement. The overwhelming majority *are* attracted by the goals and accomplishments of the organization. But it is not the social goals alone that attract them. Every board member, to a greater or lesser degree, seeks or appreciates some measure of community recognition, prestige, status, and influence for his community participation. What is more, his identification and participation in agency activity itself acts to channel these power and prestige needs in socially positive directions. The result is often that those who have the strongest need for recognition develop into the most constructive and valuable community leaders.

But if these power and status aspirations are so prevalent and important, how is it that they are hushed up and that we find so little about them in our professional literature? Why are these motivations considered in bad taste and illegitimate? Why do we confuse our students and younger practitioners and even ourselves by refusing to recognize them, study them, and perhaps discover a pattern or science that will help us in our work with lay people? Apparently it just is not done. It is obviously contrary to the Protestant ethic upon which our social and moral norms are based. It is certainly contrary to Jewish traditional ethics which go back many centuries. Note this little commentary of the *Pirke Abot* on the Talmud:

> *Let all those who labor in behalf of the community:* This is a reference to community leaders; that is, let them engage in communal work for the sake of Heaven, guiding people along an upright course, restraining them from evil ways, reproving them when necessary. And in all this their objectives must not be self-aggrandizement, acquiring honor or wealth or power or pride: For a public figure who lords it over the community is despised by God.[3]

The contradiction between stated selfless aims and realistic self-seeking objectives in our society is nothing new. From the child who is taught that certain actions are unethical which he sees his own parents practicing, to the national and international hot and cold wars for democracy and social betterment, there are gaps and lacunae between ethics and practice. The job of the social scientist is not to ignore one as against the other, but to try to bring both together into a single framework and to paint a consistent and recognizable picture with varying shades and tones.

WHO REALLY MAKES POLICY?

It seems strange that social workers, who avoid moralizing about their clients, still tend to segregate board members into "pure" and "impure" types. We have either tended to shut our eyes and ignore their prestige and power needs, or have entirely condemned them as antithetical to our agency's social goals. At best, we have accepted these needs as limitations, and have accepted them more reluctantly than limitations of budgets, building facilities, or

[3] Judah Goldin, *The Living Talmud* (New York: The New American Library, 1957), p. 82.

trained staff. Because of our attitude, we as professionals have never really allowed ourselves to trust our lay leadership to formulate the goals and policies of our agencies. We have too often manipulated and educated our boards toward accepting *our* conception of what the goals and policies should be. Our excuse has been that our lay leaders are not knowledgeable enough. Perhaps the real reason is that we have never accepted them as people, and have felt their personal needs for recognition and power as weakening and interfering with their ability to formulate policy. The temptation of some of us to become manipulators instead of enablers has fanned the spark of suspicion and distrust which many of our lay leaders have toward professionals. And so we are often considered to be "playing a game"—going through the motions to get our lay leaders to adopt decisions we have already made for them.

Wilensky and Lebeaux quote from a letter by an executive of a family service agency:

> I've been concerned and at the same time both amused and somewhat guilty about the fact that the Board of Directors makes policy decisions; both by authority of the by-laws and in the actual voting they do; yet actually in the present-day family casework agency the staff has to educate the board constantly and persistently and it certainly does choose the elements of education which lead toward the conclusion of which the staff approves. In other words, we tell them how to vote and they vote and we call that process "the board sets the policy of the agency." [4]

William H. Whyte in *The Organization Man* spurns the notion that professionals are any more capable of formulating policies than lay persons.

> . . . the scientific elite is not supposed to give orders. Yet there runs through all of them a clear notion that questions of policy can be made somewhat nonpartisan by the application of science. There seems little recognition that the contributions of social science to policy-making can never go beyond staff work. Policy can never be scientific, and any social scientist who has risen to an administrative position has learned this quickly enough. Opinion, values, and debate are the heart of policy, and while fact can narrow down the realm of debate, it can do no more.[5]

Board committees have their status hierarchy, too. In group service agencies, fund-raising activities or the membership campaign (if there is one) is often the quickest channel toward board leadership. Next in terms of prestige may come the budget, the finance, the building, and the personnel committees. The program committees are usually at the lower rungs of the ladder, and it is a common occurrence to find our program professionals urging the executive director to help them recruit articulate, aggressive board members with status as chairmen or members of their division committees. The rank-and-file working member of the program committee, who usually understands the social objectives of the agency and is more in sympathy with social work goals and methods, has least to say about the formulation of agency policies. And while a board of directors to be properly balanced must have dedicated rank-and-file workers—people who participate in agency programs as well as power and prestige members—the former usually have to work hard to win nomination, while the latter are usually sought after and cajoled to become members of the board.

But this is quite normal. As Wilensky and Lebeaux point out: "Although democratic representation from all sectors of the community might be ideal for an agency board, it usually serves the financial and other needs of the agency better to obtain what is known in social work circles as a

[4] Harold L. Wilensky and Charles N. Lebeaux, *Industrial Society and Social Welfare* (New York: Russell Sage Foundation, 1958), p. 273.

[5] William H. Whyte, Jr., *The Organization Man* (New York: Simon & Schuster, 1956), p. 34.

power board, that is, to take the American power structure into account."[6] For example, a study of administrative management of United Community Services in Detroit concluded that, assuming equal needs, "a long established and nationally known recreation agency with a power board and a middle-class clientele using its swimming pool and handball courts, stands a better chance of getting a budget increase than a little, local Community Center whose board president is the corner grocery man."[7]

WHAT ATTRACTS STATUS PEOPLE?

What attracts status persons to agency boards? Numerous factors. The social goals of the agency are one. The service the agency renders, the people it serves. Often, the presence of status people already on the board is important. As one board member was heard to remark, "I'd like to be on his team even if he were raising money for a cat and dog hospital." Another attraction for status people is a new, modern, and expensive building. Small neighborhood centers which have never been able to attract power elements have suddenly found themselves popular after successfully completing a fund-raising campaign for a new building.

Perhaps most successful in attracting and keeping prestige people on the board are those agencies in which the lay person has important decisions to make and where they are themselves closer to the field of operation. Paradoxically enough, some agencies that have more professionals, where services and functions are very thoroughly discharged by trained staff, are often less appealing to status businessmen and prestige laymen. One may note that fund-raising organizations which conduct their activities almost entirely by volunteers have high status, whereas most family agencies, which are much more professionalized and whose service is rendered in confidence by social workers, usually have a relatively weaker attraction for prestige persons.

In any case, as an attraction for power elements the social philosophy, the objectives of the agency, and the services it renders are probably not decisive, despite the fact that the agency goals are its very *raison d'etre*. True, they are important in that they surround the agency with an aura of respectability—"good deeds"—*noblesse oblige* identification. But whether the particular philosophy is Freudian or Rankian, task-oriented or growth-oriented, recreation or therapy—to most power elements in the community these have only a public relations significance. If the agency is generally considered by the public to be doing a good job, has other high status individuals on its board, operates a clean, well-kept building, and gives them a chance to do something they can do comfortably without spending too much time and effort—that is enough principle and philosophy to attract them.

Financially well-to-do, their businesses or professions stabilized and children married off, many of our high-status community leaders like nothing better than the pat of congratulation in a country club locker room or the good-natured respectful ribbing in a town club bar the day after their picture appears in the daily press or the house organ when a minor job has been completed. Privately they may express their surprise that they received so much recognition for having done so little ("You know, the staff really did it all!"). But they play the role well—with just the right amount of humility and praise for their committee members, the agency president, and the executive and his staff. They like it, and the agency benefits in its scramble for status and power people in the jungle of modern community life.

The coin of the realm for the aspiring lay leader is recognition, prestige, and

[6] *Op. cit.*, p. 269.

[7] John S. Leszezinski, *A Study of the Administrative Reorganization of the United Community Services of Metropolitan Detroit.* Unpublished M.A. thesis, Wayne University, 1955.

status. There is never too much of it, even when it may appear not quite fully deserved. The danger is rather that too little may be bestowed, souring the leader or potential leader into a miasma of bitterness, hostility, and indifference.

The importance of power and prestige as motivations and as policy-making factors in agency boards may appear to be overstressed in this discussion. It is true that some boards show very little trace of it: members are dedicated, knowledgeable, unselfish; they respect and admire professionals and make only principled decisions. They may be objective, modest, devoted, and cooperative. But let us look at the board where prestige, power, status, and recognition are not important motivating factors in participation and decision-making—the chances are that its agency has difficulty getting its budgets approved, attracting influential members, or improving and developing new facilities. This is said without criticism. For it is the thesis of this paper that *there is no basic contradiction between the aspirations for power, prestige, and recognition and dedicated devotion to agency goals.* The difficulty comes only in the way these motivations are sometimes expressed and in the manner in which we as professionals have handled them.

CONSTRUCTIVE USE OF POWER MOTIVATIONS

We are still under the influence of two contradictory nineteenth-century philosophies: liberal social thought and Freudian psychology. The former states that man is the master of his environment and that social conditions can influence and change human nature. The latter holds that man's inner nature determines the structure of society and that social conditions and relationships can be changed and improved only when man himself is freed from his inner fears and hatreds. While our social work practice has been greatly influenced by both these sociological and psychological approaches, until comparatively recently there has been very little effort made to synchronize the two into one total system to explain motivational behavior. Erich Fromm, Karen Horney, and others have been approaching this goal from one direction, while Talcott Parsons, Robert Merton, and their associates have been working toward it from another. It is this writer's belief that our field has a lot to gain and a great deal to offer as an arena for empirical studies in motivational behavior, and that we as practitioners have the opportunity to make an important contribution to this field of knowledge.

The failure to recognize and accept, along with the social goals of our agencies, the existence of unspoken motivations of prestige, status, and power as legitimate and positive factors in community life has led many of our agency administrators and practitioners into two kinds of blind alleys. One is the road taken by the professional who rigidly and uncompromisingly strives for the immediate attainment of social objectives that can be properly conceived only as long-range goals. He is inclined to be idealistic and dedicated, but naïve; he becomes disillusioned, bitter, confused, and sometimes leaves the field altogether in frustration.

The other blind alley is the dark road leading to cynicism and manipulation—boot-licking upward and repression downward. To some executives (fortunately they are few), the *modus operandi* becomes the politics of the power clique. They surrender principle to opportunism, although still striving to justify antisocial or negative policies by ideological sophistry. Perhaps they have overidentified with the power elements—have compromised and surrendered the moral and professional responsibilities of their social work role.

There are several elements that may keep agency and board membership in line toward the attainment of their social objectives. First, there is the community structure which, despite limitations and weaknesses in the selection of board membership

and leadership, *has implicit in it a considerable degree of accountability* to the community. Interest in the agency on the part of federations, community chests, and other agencies is an important element making for equilibrium and social control. The process of deficit budgeting, the planning and integration of services, however loose and voluntary, at least *establish a climate for decision-making based on social needs and community welfare.* For no matter how strong the need for power and prestige, no group or individual can justify an agency policy on that basis alone, but must also seek a social rationale; the "what's-good-for-General Motors-is-good-for-the-people" justification offends our moral sensibilities. The stated social and ethical objectives of our agencies themselves are powerful guiding and controlling factors.

Perhaps just as important are the constituency and agency membership, both real and potential. In a sense, a social agency is like a department store: the customers won't come if they don't like what you're selling. Lack of customers can be just as disastrous to an agency as to a business. If the agency's policies do not meet community needs; if its programs and services reflect no realistic objectives; if the agency structure is being used for individual or group self-aggrandizement —sooner or later the constituents will begin to drop off and look elsewhere for vehicles to meet their social and recreational needs. Dissent may break out among the members, manifested through indifference, nonattendance, or complaints. And this may be reflected in the board itself by dissension or lack of interest.

THE PROFESSIONAL'S ROLE

Important for us as professionals is a clear understanding of our role. There is first the matter of attitude—the accepting, nonjudgmental professional relationship of a worker to a group. We accept prestige and recognition needs in club and activity groups as natural phenomena and direct them, without moralizing, toward the social development of its members. We are quick to perceive overidentification or competitiveness by a club leader with members of his group. Why is it so much more difficult to carry over these attitudes in our work with boards and board committees? Perhaps because our own interests and prejudices are involved, and we have our own values and professional objectives.

Nor is this by any means to suggest that we surrender or compromise these principles and become mere technicians. Social workers are "enablers," but this has never meant giving up their responsibility for furthering the cause of justice, human dignity, and freedom. On the contrary, the optimum relationship with our board leaders and members calls upon us to exercise the strongest adherence to our professional principles. What is more, this is expected of us by our boards and lay leadership, and the professional who compromises his dedication loses their respect and confidence and forfeits the opportunity to develop proper relationships with them.

The professional may be criticized and chided for being unrealistically idealistic; but he is expected to stand up for his principles. His dedication and professional integrity are his armor, and any crack in that armor is sometimes focused upon with more criticism than if found in the attitudes or actions of volunteers. There is often a subtle or unconscious testing going on, by lay persons, of the professional's ethics and principles—a process by which the layman learns and develops his role without having to seek professional guidance openly.

In many respects the professional's role is a frustrating one. He has his own needs for status, recognition, and power. If he seeks to satisfy them within the agency structure he competes with lay members of the board and volunteers. For such satisfactions he must seek outlets outside the agency—through professional and civic groups where his participation is on an equal level with his colleagues, and where

he is himself a volunteer. In his own agency the professional has an advantage in influence by virtue of his very role. He spends more time there, is more familiar with what is going on. He has an advantage through education and training. For the sake of healthy role relationships in his agency, recognition and status-seeking on his part must be underplayed, and there should be no suggestion of competing with volunteers. But recognition and status outside the agency—through professional organizations, churches, and community groups—help the professional to maintain and extend his prestige within the agency itself.

THE AGENCY BELONGS TO THE COMMUNITY

Perhaps we tend to overlook the fact that the board of directors reflects the attitudes and opinions of the community with respect to the services, philosophy, and objectives of the agency. We are sometimes frustrated and annoyed when certain board members, especially power people, do not see objectives in the way we do, or do not agree with our social work principles. Yet the ideal board is not one whose members are all knowledgeable, progressive, democratic-minded, or dedicated to broad social work concepts. Such a board might well set up a false and unrealistic climate vis-à-vis the community's real attitudes. If the board does not genuinely reflect community opinion and the readiness of the community to accept the objectives and methods of the agency, the policies it adopts may be rejected by the community.

The dedication to professional social work principles cannot be compromised. But it must be realistically tempered and qualified by a basic understanding that the agency is a *community* agency—that it belongs to neither lay leader nor professional; that the role of the professional is that of a technician and an enabler, a professional leader with positive values and social goals; and that policies and objectives must be worked out with mutual respect through a process of accommodation and education which operates in both directions.

In the policy-making and operation of our agencies, both board members and professional staff have their unique roles to play. The understanding of how these roles differ and what their essential ingredients are will help boards and staffs to work together toward the attainment of our social objectives.

BY DAVID FANSHEL

Studying the Role Performance of Foster Parents

WHILE FOSTER FAMILY care has emerged over the past three decades as the major—and oft-preferred—form of child care for youngsters who cannot remain in their own homes, little attention has been focused upon *foster parents* as the major determinant of the quality of such care. Most of the written material of a substantial nature deals with the children involved, their own parents, and the social situation from which they come.[1]

This paper concerns a recent study that sought to develop a more meaningful picture of the individuals who serve as foster parents than has previously been available.[2] The study had both substantive and methodological objectives. We sought information about the social attitudes, role orientation, and child-rearing attitudes of foster parents; about their performance in the unusual role of foster parents; and about the suitability of their homes for different types of children. This necessitated developing methods for obtaining as reliable data as possible. We were also interested in the extent to which performance as foster parents and suitability of homes for different types of children might be predicted from certain attitudes that might be assessed before a child has been placed with the family.

The decision to focus the research upon persons actually serving as foster parents —rather than simulating the real-life situation for experimental research purposes— brought with it a number of methodological issues that need to be looked at by those who contemplate taking a similar path. The essential problem is to obtain unambiguous and reliable data from different members of a role-set; in this case, foster parents and pairs of caseworkers who had individually worked with the parents around the placement of different foster children in the home. In view of their different status positions, one might anticipate difference in perception by key actors in the foster family situation of crucial areas of role behavior.

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SUBJECTS AND SOURCES OF DATA

The study included all foster parents currently caring for children for the agency as well as those on call and awaiting the placement of a foster child, a total of 102 foster families, all but one of whom voluntarily participated in the study. The data were derived from interviews with foster parents, an attitude questionnaire administered to foster mothers, and schedules completed by caseworkers. Each of these will be discussed briefly.

Interviews with foster mothers and foster fathers. A 32-page interview schedule combining open-ended and precoded questions was developed and pretested. Many of the precoded items were incorporated in the

[1] Notable exceptions are the work of Howard Stanton and Martin Wolins. *See* Howard Stanton, "Mother Love in Foster Homes," *Marriage and Family Living*, Vol. 18, No. 4 (November 1956), pp. 301–307; Martin Wolins, "The Problem of Choice in Foster Home Finding," *Social Work*, Vol. 4, No. 4 (October 1959), pp. 40–48.

[2] A report of this study, which was supported by the Field Foundation and conducted at the Family and Childrens Service in Pittsburgh, Pennsylvania, is being prepared for publication.

schedule on an a priori basis in order to develop attitude scales of the Guttman type. In its final form, it was found that the interview took two to two and a half hours to complete. The interview was conducted with the foster mothers in their homes by four trained caseworkers employed for this specific purpose.

On the whole, tolerance for the interviewing procedures was good, with only an occasional instance of serious irritability shown by the foster mothers. Nevertheless, the interview was uniformly seen by the interviewing staff as taxing to the respondents. This experience points up one of the major problems of attempting direct research with foster parents, namely, their tendency to be nonreflective, "doing" kinds of people. The interviews with the foster fathers were shorter in duration because of their more tenuous relationships with the agency. Most of the discussion in this paper will concern the foster mother as the object of research interest.

The Parental Attitude Research Instrument (PARI). This paper-and-pencil attitude questionnaire was administered to the foster mothers while the foster fathers were being interviewed. This instrument was developed by Shaefer and Bell to meet the need in a number of fields for a device to assess child-caring practices and attitudes.[3] It consists of 115 statements (23 scales of 5 items each) devised to measure maternal attitudes relevant to personality development in children. The subject has the choice of "agreeing strongly," "agreeing mildly," "disagreeing mildly," or "disagreeing strongly." The PARI is currently being tested with various parent groups throughout the country, including parents of so-called normal children, parents of schizophrenic children, parents of patients in child guidance clinics, and so forth. As far as is known, the research reported here represents the first attempt to utilize PARI with foster parents.

The Foster Parent Appraisal Form (FPAF). This instrument was constructed to obtain the judgments of caseworkers on the role adjustments of the foster parents with whom they had worked. It included ratings of the handling by the foster parents of the children entrusted to their care, their patterns of child-rearing, the quality of their family relationships, their social characteristics, and their usability for various kinds of children requiring care. The form required the caseworker to make some 135 ratings on ten-point scales. The staff was trained in the use of the FPAF at a two-hour training session followed by individual consultation with the research person. Case illustrations and definitions were provided to help anchor the caseworkers' ratings along common dimensions. It was possible on 88 out of the 101 foster families in the study to obtain independent ratings from two caseworkers who had worked with the same foster family and thus to test the reliability of the rating instrument.

Many of the findings of the study have sufficient relevance to practice to justify further exploration in the same and other settings. The remainder of this paper will be devoted to examples of such findings and to certain methodological questions.

SOCIAL ATTITUDES, ROLE ORIENTATION, AND CHILD-REARING ATTITUDES

The interplay between broad social attitudes and specific beliefs about child-rearing was an important area of interest in this study of foster parents. While the interviews with foster parents included a number of scales developed to measure their attitudes on a variety of issues, this discussion will be confined to two: (a) the Anomie Scale and (b) the Benefactress of Children Scale.

The Anomie Scale, developed by Leo Srole, has been the object of some speculation in the sociological literature with re-

[3] E. S. Schaefer and R. Q. Bell, "Development of a Parental Attitude Research Instrument," *Child Development*, Vol. 29, No. 3 (September 1958), pp. 339–361.

spect to the nature of the attitude it is said to measure.[4] Srole speaks of the scale as measuring "interpersonal alienation." A person scoring high on this scale is one who appears to have a profound cynicism about the motives of people around him, including neighbors, persons in the public trust, and so on. It is accompanied by a pessimistic view about the future outlook for man. Those who score low on the scale have a more positive social outlook and are said to have high morale. Although most of the foster parents in our study revealed a positive social outlook, a substantial minority revealed anomic tendencies.

How does the foster mother's general outlook relate to her role orientation? A number of questions were posed to the subjects which, on the pathological end of the scale, were indicative of a rather overbearing, immodest posture that implied that foster parents were very special people whom others could not adequately appreciate, much less emulate. This scale was somewhat facetiously given the name "Benefactress of Children." The items included in the scale constituted a unidimensional measure of this quality and had a coefficient of reproducibility of 90.6:

a. People who neglect or mistreat their children should be severely punished by society (72 out of 101 foster mothers agreed a great deal).

b. Being a foster mother requires a very strong love for children which only a few people have (50 agreed a great deal).

c. The money foster parents receive is very inadequate considering the service they are asked to perform (18 agreed a great deal and 26 expressed some agreement).

d. Adoptive parents do not appreciate the contributions of the foster parents to the child's welfare (7 agreed a great deal and 16 expressed some agreement).

The evidence suggests that this attitude is indeed related to anomie, for the product-moment correlation of scores on the two scales was .58.[5] The establishment of a close relationship between an individual's expression of estrangement from her society and her fellow human beings and an essentially exploitive use of the foster parent role (perhaps to overcome feelings of personal inadequacy) is a matter that bears some reflection. Among other things, it suggests the possibility of broadening the base of significant behaviors observed by caseworkers in assessing the suitability of applicants for the foster parent role.

The further importance of the foster mother's rating on the Anomie Scale is suggested by the finding of significant correlations between scores on this scale and sixteen of the PARI scales said to measure pathogenic attitudes. Thus anomie scores correlate with scores on such scales as Fostering Dependency ($r = .40$), Seclusion of the Mother ($r = .40$), and so on. Thus there appears to be a strong association between a cynical, soured social outlook as reflected in the Anomie Scale and a negativistic, somewhat harsh and undemocratic attitude toward children. It should be noted that most of the PARI scales significantly correlated with the Anomie Scale showed loadings on the factor extracted by Zuckerman in his factor analysis of the PARI, which measures authoritarian, suppressive, punitive, and restricting types of attitudes.[6] However, he cautions that this factor is so

[4] Leo Srole, "Social Integration and Certain Corollaries: An Exploratory Study," *American Sociological Review*, Vol. 21, No. 6 (December 1956), pp. 709–716. *See also* A. H. Roberts and M. Rokeach, "Anomie, Authoritarianism and Prejudice: A Replication," *American Journal of Sociology*, Vol. 61, No. 4 (January 1956), pp. 355–358; E. Cumming *et al.*, "What Is 'Morale'? A Case History of a Validity Problem," *Human Organization*, Vol. 17, No. 2 (Summer 1958), pp. 3–8; and Gwynn Nettler, "A Measure of Alienation," *American Sociological Review*, Vol. 22, No. 6 (December 1957), pp. 670–677.

[5] For an N of 101, an r of .20 would be significant at the .05 level and an r of .25 at the .01 level of probability.

[6] M. Zuckerman, B. B. Ribback, I. Monashkin, and J. A. Norton, "Normative Data and Factor Analysis on the Parental Attitude Research Instrument," *Journal of Consulting Psychology*, Vol. 22, No. 3 (June 1958), pp. 165–171.

broad that it may be measuring a general response set to the test as well as specific response to the content of the scales.

RELIABILITY OF APPRAISAL OF THE FOSTER PARENTS

Examination of the correlations of ratings by pairs of caseworkers who had worked with 88 of the foster families on some 40 key variables from the Foster Parent Appraisal Form (FPAF) yielded disappointing findings. The reliabilities of caseworker-raters for the 40 variables ranged from .25 to .81, with a median of .51. Since low reliability on these ratings raises some question about the degree to which a professional discipline is operating to guide the worker in his judgments in daily practice, this is indeed a serious matter. Several possible explanations for the lack of consensus between caseworkers in this study suggest themselves.

1. The fact that caseworkers had experience with the same foster parents but around *different* foster children semed to lower the reliability of ratings. In other words, if caseworker A supervised the placement of a normal female infant in the Jones foster home and was very impressed with the care the baby received, her ratings tended to have a positive cast. Caseworker B on the other hand, placing an active three-year-old boy with Mrs. Jones and finding her to be quite unresponsive to him and resentful of his activity, tended to assign ratings that had a distinct negative cast. This is the well-known "halo effect."

2. The fact that one caseworker may know the family very well and the other know it more superficially tends to depress reliability. Previous research by Wolins has shown that variation in sheer quantity of information affects the judgments of caseworkers.[7]

3. The fact that the caseworker who is making the ratings is also involved in interaction with the subject is another source of error. The data in our study demonstrate that foster parents behave differently with different caseworkers, and it is not illogical to assume that the latters' ratings are affected by this.[8]

4. A major source of low reliability of ratings may also of course be due to the defects of the instrument itself and of its administration. Here we are in a dilemma revealed by Wolins in his experimental study, where he found that giving caseworkers only a limited amount of instruction tended to be more confusing than clarifying. In order to obtain high reliabilities, he had to involve the casework staff in major training sessions.

5. Finally, there may be serious limitations to the caseworker, or to any human being, as a "processor of information." Hunt feels these limits are reached fairly soon whether the rater be a social worker, psychiatrist, or a clinical psychologist.[9]

After this formidable listing of all the sources of possible error that can affect the reliability of ratings of foster parents by two caseworkers, one might well wonder why anyone would want to undertake such hazardous research. The answer lies in the basic fact that in the real-life situation confronting the caseworker he must make exactly these kinds of decisions and often under the most hectic circumstances and with little information in hand.

FACTOR ANALYSIS OF THE RATING INSTRUMENT

Although the caseworkers' judgments showed only modest reliability, it seemed worth while to scrutinize these with a view

[7] M. Wolins, *op. cit.*, p. 43.

[8] It was found, for example, that foster parents receiving high performance ratings tended more often to seek the worker out for help with problems related to the care of the foster child than those receiving low ratings.

[9] J. McV. Hunt, "On the Judgments of Social Workers as a Source of Information in Social Work Research," in Ann W. Shyne, ed., *Use of Judgments as Data in Social Work Research* (New York: National Associatiotn of Social Workers, 1959), pp. 38–52.

to determining whether they showed an underlying structure. Identifying common factors underlying ratings on the FPAF would contribute to understanding foster parent behavior as perceived by caseworkers and facilitate examination of the relationship of the caseworkers' perceptions to attitudes expressed by the foster parents themselves. Forty key variables from the rating instruments were intercorrelated and were factor-analyzed, using Thurstone's centroid method. Ratings of caseworkers A and B for each foster family were kept separate in this analysis, since there was interest in the pattern of correlations for each individual rater. Six factors were extracted.

Factor A is interpretable as a rather inclusive evaluative factor on which 28 of the 40 ratings had loadings of .30 or better. It measures the foster parent's *ego strength* or *parental competence.* The variables with the highest loadings include such items as the foster mother's understanding of child behavior, her understanding of her own emotional needs as a foster parent, the warmth shown to children entrusted to her care, and so on.

Factor B describes the degree to which a family is democratically or autocratically oriented. At one pole of this factor is the driving, manipulative foster mother who tends to play a decided leadership role in the family. With children, great stress is placed upon general conformity to a strict set of standards. Such foster parents tend to withdraw from a child and deny him affection when he has committed an infraction of the rules. As might be anticipated, it was found that a significant negative correlation existed between Factor A scores and Factor B scores. These two factors show strong resemblance to those extracted from a number of rating instruments constructed by child development researchers studying *parent* behavior.[10] It would appear from this study and the work of other researchers that there is a limit to the number of meaningful descriptive ratings that can be made of parent behavior. At the same time, other factors were extracted from the caseworkers' ratings which related specifically to the *foster parent role.*

Factor C is related to the capacity of foster parents to tolerate children with biological deficits. Thus if a home was rated by a caseworker as able to accept a mentally retarded child, it was also apt to be described as able to absorb a child with a severe physical handicap, an infant suffering from colic, or a youngster who shows bizarre behavior. Such a foster mother is described as not needing to care for foster children to bolster an inadequate sense of her own femininity, and a child with physical defects or suffering from mental retardation does not threaten her self-image.

Factor D suggests that caseworkers tend to view foster homes as being suited for the care of infants or older children but not both. Somehow no evaluative factors appear loaded upon this factor. It would seem that the raters did not have a clear image of the psychological attributes necessary for infant care. It may well be that it is simply very difficult for caseworkers to perceive meaningful areas of psychological interaction between foster mothers and infants during the brief periods they are in the home.

Factor E relates to the motives of the foster mother. On the negative side, it appears to describe a foster mother who seems to assume the foster parent role in order to "undo" maternal deprivation she herself experienced as a child. She is also described as having difficulty in separating from foster children placed in her care.

Factor F describes a cluster of ratings which relate to a foster family's ability to provide care for the "acting-out" youngster. A family with a high rating is able to tolerate the child who is reportedly fresh to grown-ups, the adolescent girl who is sexually precocious, the older child, and the child who shows bizarre behavior.

[10] *See* M. Roff, "A Factorial Study of the Fels Parent Behavior Scales," *Child Development,* Vol. 20, No. 1 (March 1949), pp. 29–45; M. Lorr and R. L. Jenkins, "Three Factors in Parent Behavior," *Journal of Consulting Psychology,* Vol. 17, No. 4 (August 1953), pp. 306–308.

It is thus interesting to find that the caseworkers did not show a tendency merely to describe *good* and *bad* foster parents but instead made functional discriminations according to specific types of children they judged could be served by the subjects of the study. Thus the fact that a family could take care of an aggressive youngster did not necessarily mean that it could absorb a mentally retarded child.

PREDICTABILITY OF CASEWORKERS' RATINGS

We now come to a third question which has been raised about the caseworker ratings: How are these ratings linked to the responses of the foster parents in the research interviews and on the Parental Attitude Research Instrument? While it is useful to analyze the ratings of caseworkers in terms of their underlying structure, the extent to which these ratings can be predicted from the subjects' own perceptions is a more general and more useful kind of question for casework research.

The approach used in this study was to develop factor scores for each foster family along the dimensions previously outlined. These factor scores were obtained by pooling the ratings of the two workers who knew the families in 88 of the cases where pairs of raters were involved, and by using the single worker's ratings in the remaining 13 families. These scores were then correlated with data obtained in the research interviews with the foster parents and their PARI scores.

Because of the low reliabilities of the caseworker ratings and because it was frequently demonstrated in the research interviews with the foster parents that they were not always candid about their feelings nor introspective about their motivations in being foster parents, it was expected that the correlations between the productions of the caseworkers and of the foster parents would be quite low. Nevertheless, it was hoped that leads would be developed for future research with foster parents. It should be pointed out further that the substantive content of the two sets of data are not theoretically exact replicates of each other. This would be the case only if the caseworker were asked to predict the responses of the foster parents in the research interviews and in the PARI test situation, and only then would the correlations be expected to approach unity.

The factor scores correlated with few of the scores based on the interviews with the foster mothers. However, some of these associations were suggestive. For example, a significant correlation was found between the rating of a foster parent's capacity to accept a biologically handicapped child *(Factor C)* and the score achieved by a foster mother on an index called "Capacity to cope with problems of foster children." In other words, the caseworkers and the foster parents tended to be in agreement with respect to the ability of the foster parent to absorb children who presented some difficulty in care.

Looking at *Factor D*, the one dealing with the ability of the foster home to absorb either infants or older children, we find a number of interesting correlations with material produced by the foster parents. Thus, foster parents who were described by caseworkers as being able to absorb older children tended to be those who were significantly involved in community activity, whereas those who cared primarily for infants tended to be social isolates as measured by an Index of Social Participation. If a family is to accept a child who is a potential source of interaction with neighbors, it would appear logical to expect such a family to have comfortable relationships with the families who live around them.

The most promising kind of predictive correlation was found to exist between the factor scores based on caseworker ratings and the scores achieved by mothers on the Parental Attitude Research Instrument. For example, the foster mothers who were rated high on *Factor A*, which describes a foster parent with good "ego strength" and "parental competence," were also indi-

viduals who in their PARI scores tended to eschew pathogenic child-rearing attitudes. *Factor A* showed significant negative correlations with such scales as Seclusion of the Mother, Martyrdom, Fear of Harming the Baby, Excluding Outside Influences, Suppression of Sex, and Intrusiveness. In other words, foster parents who were judged by the caseworkers who worked with them to have considerable ego-strength in their functioning as parents revealed this strength in a paper-and-pencil situation, which thus tended to validate the caseworker's ratings.

In looking at *Factor B,* which describes an autocratic as opposed to a democratic foster home, we found a significant negative correlation with the PARI scale called Encouraging Verbalization. Thus foster parents who are described as autocratic by caseworkers reveal this quality in a paper-and-pencil test.

Parents who scored high on *Factor E,* which describes a foster family in which the foster mother needs to "undo" the parental deprivation she herself experienced, tended to voice a number of pathogenic attitudes as reflected in such scales as Seclusion of the Mother, Martyrdom, Suppression of Aggression, Ascendance of the Mother, and Acceleration of Development. They also tended strongly to reject an equalitarian approach to the child. There were a number of other factors which correlated significantly with some of the PARI scales. Thus the correlations of the factor scores with the PARI scales are more impressive than with the scores derived from the direct interviews with the foster parents.[11]

GLOBAL RATING OF ROLE PERFORMANCE

The caseworkers were asked, in addition to other ratings, to make a global judgment of the over-all performance of the foster parents with *each* child supervised by them, taking into account all of the difficulties presented by the child, his family, and by environmental circumstances outside their control. Any foster home that received a "poor" or "less than adequate" rating in its handling of *any* child who had been placed in the home was categorized as belonging to the *low performance* group. Any home that consistently received a rating of "excellent" or "good" for all the children who received care from the foster parents was categorized as belonging to the *high performance* group. This was an admittedly severe standard, since one failure was sufficient to place a family in the low performance group. However, since the aim of practice is to develop foster families who can *consistently* provide adequate care to children, it was felt that this standard made sense. Sixty of the foster families were thus located in the high performance group and 41 in the low performance group.

When the *low* and *high* performance groups were compared with respect to their scores on the Parental Attitude Research Instrument, it was found that they were significantly differentiated from each other on six of the pathogenic scales, with the *high* performance group tending to repudiate these attitudes and the *low* performance group supporting them. This is an important finding, since it points to the potential usefulness of the PARI as an aid to the caseworker in screening new applicants for the foster parent role. While complete dependence upon the PARI for such decisions would not make sense at this preliminary stage of research, the instrument would appear to have value in alerting the caseworker to pathogenic attitudes that might mitigate against successful performance as a foster parent.

DISCUSSION

Attempting to develop instruments that will predict the performance of foster parents is a goal that is fraught with many methodo-

[11] The correlations reported here were shown to be even stronger when a correction for the response-set phenomenon was applied. A method for converting raw scores by using each subject's own mean and standard deviation has been developed by Bell, and the IBM program for this was made available for this study.

logical problems. Data secured directly from the foster parents are limited by the fact that these subjects show difficulty in their ability to articulate their views candidly in many areas. This kind of self-censorship seemed to be more strongly operative during the in-person interviews than in the paper-and-pencil situation as reflected in the correlations with the caseworkers' ratings. One might conjecture that the test situation affords a greater sense of privacy than is true in direct confrontation with an interviewer.[12]

We have also seen that the reliability of the caseworkers' ratings tends to be low because of complexities of the real-life placement situation. Considering the low reliabilities of the ratings as well as the fact that the caseworkers were not asked to replicate the responses of the foster parents, the finding of a fair number of significant correlations, in a predicted direction, leads one to hope that research instruments can eventually be developed to help make foster family placement not only a preferred form of care but also one that is scientifically tailored to the needs of each child.

[12] This methodological issue is concerning a number of investigators. *See* J. Walters, "Relationship Between Reliability of Responses in Family Life Research and Method of Data Collection," *Marriage and Family Living*, Vol. 22, No. 3 (August 1960), pp. 232–237.

BY CURTIS M. LYLE AND OLGA TRAIL

A Study of Psychiatric Patients in Foster Homes

THERE COMES A point in every public hospital program when patients who have not fully recovered from neuropsychiatric illness far outnumber the acute cases and first admissions. These persons usually reach a plateau of behavioral adjustment where there is no further marked improvement or remission of psychotic manifestations. They are not different from many who leave the hospital earlier without achieving remission. Yet they become the bulk of the hospital population, are housed in "continuous treatment" wards, go through the motions of participating in the hospital program, and all too frequently come to see the hospital as a home and the program as a part of the routine of living rather than as preparation for eventual departure.

In tacit recognition of this situation, "home care" or "foster home" programs have been developed by many hospitals as a means of moving some of these persons out. Administrators have seen in this development an alternative to continuing increases in the size or number of institutions, and treatment staff has welcomed the increase in turnover which would raise the proportion of new admissions and—it is to be hoped—better prognoses.

The development and steady expansion of home care or foster home programs in many hospitals—state, federal, and private—reflect their growing value to hospital management. What is perhaps less well known or publicized is the more important fact that in well-administered programs a substantial degree of social and emotional rehabilitation is achieved by those severely handicapped persons who are placed in homes appropriate to their needs.

This paper has grown out of a study of patients placed in the foster home care program of the Veterans Administration Hospital at American Lake, Washington. The foster homes used were generally within a 35-mile radius of the hospital. They varied in character and location, including those with urban, suburban, small-town, village, and rural environments. The foster families also varied in background, social status, interests, and capacities. There were marked variations in the personalities, capacities, and needs of the veterans who were placed with these families. Basic to the relationships of patient and foster family were the need of the veteran for a continuing protective, yet stimulating, contact and living situation and the interest and ability of the foster family in providing this.

Seventy-seven patients were placed on foster home care between January 1, 1952, the beginning date of the program at this hospital, and August 31, 1955. Of these, 46 adjusted, or remained out of the hospital continuously for more than two years. Thirty-one were returned to the hospital, or were readmitted after having attained discharge, within two years of the date of foster home placement. Of the latter, 23 returned because of poor social adjustment or failure to maintain the psychiatric stability which had led to their consideration for inclusion in the foster home care program. Eight others were returned for treatment of non-neuropsychiatric illnesses.

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These 8 persons were eliminated from the study because the presence of acute somatic illness could not be equated with conditions affecting the others. Our study group then, was composed of 46 "adjusted" patients and 23 "nonadjusted," or a ratio of 2 to 1. Forty-six, or two-thirds of all patients, were schizophrenics. Most of the remaining third had chronic brain syndromes. Of the 69 persons included in the study, 60 were psychotic.

Hospital records were the source of all information collected and used with reference to preplacement status and characteristics of the subjects. Bias may be present in the ratings of postplacement data, since these were made by the social worker who was responsible for placement, supervision, and services, as well as for return of the patients to the hospital in the event of failure to adjust. Such data have been widely used in evaluation research, with or without recognition of the inherent bias, because they are usually the only information of a clinical nature readily available. Objectivity was insured, so far as possible, by rating a series of specific items of information which pertained or did not pertain to the individual, without resort to global ratings of adjustment. The criterion for adjustment—two years of uninterrupted stay out of the hospital—is in itself severe.

HYPOTHESES AND DATA USED

The following hypotheses were tested in the study:

1. Prognosis for adjustment in homes other than their own for neuropsychiatric patients with marked residuals of illness is related to past and present social status, behavioral status for several months immediately prior to placement, and habits and interests of the patients as observed within the hospital.

2. Attitudes and habits shown by the patients within the foster home setting (a) may vary from their habitual modes of behavior within the hospital, and (b) will be related to adjustment or nonadjustment.

3. Additional factors, such as the marital status of the foster parents or sponsor, the nature of the relationship that develops between patient and sponsor and between patient and community, and the patient's feelings about the home setting, are related to foster home adjustment.

To test these hypotheses, three kinds of data were used.

Factual information from records.

1. Age at time of placement.
2. Marital status.
3. Duration of current hospitalization.
4. Clinical diagnosis (categories: schizophrenia, chronic brain syndrome with psychosis, chronic brain syndrome without psychosis, chronic brain syndrome with convulsive disorder, all other diagnoses).
5. Financial status (accumulated funds and resources, and current income).

Clinical, observational, or judgmental information from records (tabulated by the research social worker). These items generally pertain to the 6-month period immediately preceding placement.

1. Psychiatric symptoms (hallucinations, delusions, withdrawal, erratic or irresponsible behavior, mannerisms, irritability, regression, confusion).
2. Physical health status (notation of all medical treatment or defects on record).
3. Participation in physical medicine rehabilitation service activities (occupational, manual arts, industrial, physical-corrective, and educational therapies).
4. Known interest (hobbies, recreations).
5. Attitudes (helpfulness with ward work, friendliness, co-operativeness, interest in leaving).
6. Manners (personal cleanliness, care of clothing and surroundings, courtesy, dependability, handling of funds).

(7. Intelligence—this item was attempted but abandoned, because reliable information was generally not on record.)

Ratings made by the foster home care social worker, from social service records and from professional knowledge obtained in the process of placement and of ongoing

supervision of both the patients and the foster homes.

1. Psychiatric symptoms (as enumerated in the previous tabulation from clinical records).
2. General health (known medical treatment or health problems).
3. Work activities (patient putters, helps with housekeeping, works toward payment for care, earns board and wage, works in competitive employment).
4. Recreational interests (active sports, spectator events and sports, hobbies, social activities, solitary activities).
5. Attitudes (helpfulness, friendliness, cooperativeness, acceptance of home, acceptance of sponsor).
6. Manners (as enumerated in above tabulation from clinical records).
7. Relationships in foster home (close ties with foster family, emotionally reserved, "boarder," ambivalence, antagonism).
8. Community relationships (constructive, withdrawn, destructive).
9. Patient's economic status prior to admission to hospital.
10. Patient's status as self-supporting or dependent prior to hospitalization.
11. Conspicuously psychotic appearance of patient, or not, at time of placement (appears unusual to laymen).
12. Marital status of foster home care sponsor.

In preparing all data, both the research social worker and the foster home care social worker knew which patients had adjusted and which had not. But these two persons worked independently, and data and ratings were not compared until they were complete and ready for analysis. Conscious effort was made to insure consistency in criteria and procedures as applied to the two groups.

The chi-square test, corrected for continuity, was applied to all data; relationships which are reported as being significant reach or exceed the .05 level of confidence.[1]

[1] "Chi-square" (χ^2) is a method of testing to determine whether the distribution of the measured events, or data, is different from that which might occur by chance. "Correction for continuity" is a means of making the test more exacting, to guard against the distortion which may occur in distributions derived from numerically small samples. "Confidence level" is an expression of the percentage of times the particular distribution of the data might be expected to occur by chance. Thus a confidence level of .05, as here ascribed, means that this distribution of events would occur by chance alone on the average of 5 times in one hundred such measured samples; .01 would indicate this might occur once in a hundred, and .001, once in a thousand.

FINDINGS: FACTUAL INFORMATION

Three of the five items of factual information from hospital records proved to be significantly related to adjustment: (1) age at time of placement, (2) duration of current hospitalization, and (3) clinical diagnosis.

Average age for the adjusted group was 51.4 years and for the nonadjusted 36 years. Modal age range for the adjusted was 60 to 69, and for the nonadjusted, 30 to 39. Proportions of persons in the middle age ranges (40 to 49 and 50 to 59) were roughly comparable, while more of the age group of from 20 to 29 were in the nonadjusted group and all of the few past 69 were in the adjusted group. Since all patients had been selected for inclusion in the foster home care program on a clinical basis, any factor herein described is related only to its occurrence in this preselect sample, and does not hold equal significance in relation to the hospital population at large. From these data it is evident that prognosis for adjustment in foster homes is directly related to age. Significance was established for findings regarding those under and over 40, the older group having achieved the greater proportion of successful adjustments.

The duration of current hospitalization is also directly related to prognosis for foster home care adjustment. Average hospital stay for the adjusted group was 10.7 years, as compared with 5.3 years for the nonadjusted. Chi-square significance is approached at the 10-year point of hospital stay. Significance is achieved when the division is made at the 20-year interval. Since the mean duration for the adjusted group was 10.7 years, the fact that significance was

attained at the 20-year interval reflects only an awkward arrangement of data and does not imply that prognosis is good only for those who had extremely long periods of hospitalization.

Of clinical diagnoses, chronic brain syndrome with convulsive disorder was found to be negatively related to adjustment on home care. Of six persons with this diagnosis, five failed to adjust. A relationship between chronic brain syndrome (without convulsive disorder) and adjustment is suggested but not demonstrated. Approximately two-thirds of those in each adjustment group were schizophrenics.

Significant relationships for Item 2, marital status, and Item 5, financial status, were not found.

FINDINGS: CLINICAL INFORMATION

Clinical information and observations which were extracted from clinical records of the six-month interval immediately preceding foster home care placement proved to bear significant relationships to subsequent adjustment or failure to adjust. Of psychiatric symptoms, erratic behavior was linked with failure. Erratic behavior may be defined as inappropriate, troublesome, or "acting out" manifestations indicating indifference or disregard for conventional modes of conduct, or emotional instability beyond acceptable limits. Establishment of positive relationship between presence of mannerisms and favorable prognosis for adjustment is narrowly missed. There is also a suggestion of positive relationship between withdrawal and subsequent adjustment (between the levels of .05 and .10). While the suggestion that presence of certain behavioral manifestations and capacity for adjustment are linked may seem surprising, it may seem more plausible in relation to the fact that long-term hospitalized patients, more of whom had these characteristics, were found to be more successful on home care.

Under Item 5—"attitudes"—the attitude toward leaving the hospital was negatively related to prognosis for adjustment. Ninety-one percent of the nonadjusted persons had expressed interest in leaving, as compared with 57 percent of those who adjusted. It may be speculated that those expressing an interest in leaving were in more active conflict with their feelings of dependency. Significance for this item passes the .01 level. Since most of those placed on home care had been friendly, co-operative, and had engaged in some ward work, these factors did not tend to differentiate the two groups.

As to Item 6—"manners"—dependability differentiated between the groups at the .01 level, 63 percent of the adjusted having been described as dependable versus 26 percent of the nonadjusted.

While these items were all for which clearly significant relationships were found, Item 4—"known interests"—proved sensitive. Seventy-one percent of the adjusted group had one or more known avocational or recreational interests, as compared with 48 percent of the nonadjusted group. This was suggestive of significance at the .10 level of confidence. In all other items derived from clinical records the two groups were more similar than dissimilar.

FINDINGS: FIELD INFORMATION

Examination of data regarding actual performance of these veterans during their stays outside the hospital has yielded significant findings both in trends in the course of home care and in differences between the adjusted and nonadjusted groups.

There were some marked changes in symptoms as compared with those which had been observed or noted in the last few months of hospitalization. This may be, in part, because of more detailed knowledge or reporting of behavior in the intimate setting of the home. Symptomatic behavior, especially in chronic patients, may be well known but not mentioned in routine recording on the ward. For these reasons the changes may reflect differences in observation and recording rather than actual change in the patients. Yet it is reasonable

to assume that patients have changed some aspects of their behavior in adjusting within entirely new situations and surroundings.

"Withdrawal" decreased markedly in both the adjusted and nonadjusted groups. "Regression" was noted as being characteristic of 41 of these 69 patients prior to placement. After two years in the foster home setting only 11 remained regressive, and these were all in the adjusted group. Significance for changes in both withdrawal and regression surpasses the .001 level of confidence.

There was a marked decline in "irritability" and an increase in "delusions." These changes were pertinent to both groups and did not serve to differentiate between them.

There was a marked and equal decrease in health problems within both groups in the foster homes. This finding is pertinent with regard to minor health problems only, since eight persons with major health problems, all of whom returned to the hospital for medical reasons, were eliminated from the study.

The adjustment groups are clearly differentiated by the level of recreational interests, the adjusted group having engaged in significantly more spectator sports and entertainment events, and in more hobbies, than the nonadjusted group. Sixty-one percent of adjusted veterans were "spectators" as compared with 30 percent of the nonadjusted; 26 percent of the adjusted had hobbies, while only 4 percent of the nonadjusted showed this interest. Very few in either group participated in active sports.

Because attitudes of the patients weighed heavily in their selection for home care placement, almost no differences on this basis were observed with regard to their helpfulness, friendliness, and co-operativeness. Substantial differences were noted between groups in attitude toward the homes in which they were placed and toward the sponsors. Eighty-nine percent of the adjusted group liked their new homes and 93 percent liked their sponsors. This contrasts with 57 and 52 percent of the nonadjusted who liked the home and the sponsor. Significance for these items is above the .001 level.

The nature of the relationship that developed between patient and sponsor also proved to be significant. Of the adjusted group 69 percent formed close ties with the foster family. Only 10 percent of the relationships in the group were characterized by ambivalence or antagonism between patient and sponsor. Of the nonadjusted group only 35 percent formed close ties, while 43 percent were characterized by ambivalence or antagonism. Significance for these findings passed the .01 level on close ties and the .001 level on ambivalence or antagonism. Twenty-two percent of each group maintained neutral or reserved patterns in their relationships within the foster home.

Significance of relationships is affirmed in relation to the community. Sixty-five percent of the adjusted group had constructive or morale-building experiences in their contacts with persons outside the home, while only 4 percent of this group encountered ambivalence or rejection. Of the nonadjusted, 22 percent had constructive relationships with the community while 52 percent experienced poor relationships. Significance for these findings again surpassed the .01 and .001 levels, respectively. Less than one-third of each group remained withdrawn and were not affected by contact with the community.

Work activities did not serve to differentiate the adjusted and nonadjusted groups. It is noted that a minority of all patients on home care have been engaged in employment for remuneration, whether for wages or in partial payment for board.

Of the remaining items, none proved to be significantly related to either success or failure (patient's economic status prior to hospitalization, his status as self-supporting or dependent before entering the hospital, whether or not his appearance was conspicuously psychotic at time of placement in foster home, and marital status of foster home sponsor).

SUMMARY

Hypothesis 1, that prognosis for adjustment in homes other than their own for neuropsychiatric patients with marked residuals of illness is related to past and present social status, behavior status for several months immediately prior to placement, and habits and interests as observed within the hospital, is sustained by findings that

1. Older patients have had the greater proportion of success in remaining out of the hospital after placement on home care.
2. Patients who have been hospitalized for prolonged periods have remained out after placement with greater frequency than have those with shorter hospitalization.
3. Those who have demonstrated dependability, or who have tended to conform to behavioral expectations of the staff within the hospital, generally got along well in their foster home settings.
4. Those whose behavior was characterized as erratic or nonconforming at times within several months of placement had a high rate of return to the hospital.
5. Those with chronic brain syndromes who were subject to convulsive seizures had a higher rate of return to the hospital than did those without history of seizures.
6. Those who were anxious to leave the hospital returned with greater frequency than did those who were either initially resistive or indifferent when foster home placement was proposed.

Hypothesis 2 (a), that attitudes, habits, and modes of behavior would change with the change in environment from hospital to foster home, is supported by findings of significant decreases in withdrawal, regression, irritability, and minor health problems for both the adjusted and the nonadjusted groups. Increase in reported delusions as noted in both groups lends further support. Part (b) of this hypothesis—that these changes would be related to adjustment—is not sustained, since their distribution did not serve to differentiate the two groups.

Hypothesis 3, that the marital status of the foster home sponsor, the nature of the relationship that develops between patient and sponsor and between patient and community, and the patient's feelings about the home setting are related to foster home adjustment, is sustained in all particulars except the first—marital status of sponsor. Those patients who had positive attitudes toward the home, who developed or were able to accept close relationships with the sponsor, and who met with supportive or accepting attitudes on the part of others in the community generally adjusted; those who did not generally found it necessary to return to the hospital. Marital or familial status of the sponsor made no apparent difference; patients seemed to do equally well in homes of married couples, widows, and widowers.

CONCLUSIONS AND IMPLICATIONS FOR TREATMENT

Patients who fit in foster homes are characterized by the predictability or stability of their behavior within the hospital, their capacity for relating to some persons in their environment, and their lack of initiative or drive toward change in their situation. It has been found that these qualities tend to be associated with patients who have passed middle age (those over 40) and with those who have been hospitalized for periods of more than 10 years. Chances for success are improved if the patient has some recreational interests that can be sustained in his new living situation.

Foster home situations that fit the needs of these patients are found to be those in which relationships between foster family and patient are characterized by mutual acceptance. In addition, the home and its location or environs must meet with the patient's approval. The attitudes of persons in the community must be supportive toward the patient, or at least not rejecting.

Benefits derived by patients in foster homes have included increasing social participation and diminution or reversal of re-

gressive tendencies. They became more alert, active, and interested in their surroundings. In some instances facial expression and bodily posture and bearing changed so markedly that persons who had known the patients in the hospital were frankly amazed at the change. To some extent these benefits seemed to accrue to those who found it necessary to return to the hospital as well as to those who became emancipated.[2]

These findings indicate that patients who have attained stability in their behavior, and who have potential capacity for constructive relationships with even a very few people, may be helped to move from institutional living and make further progress toward resocialization in carefully selected homes other than their own. Findings that withdrawal and regressive tendencies decreased during foster home placement, both for those who remained outside the hospital and those who were returned, indicate that this type of care has a stimulating effect upon the "institutionalized" patient. The number and variety of pathological symptoms which were observed among these persons, and the fact that with the exception of erratic or unpredictable behavior they were not significantly related to ability to adjust in foster homes, reflect the tolerance, acceptance, and understanding with which even very sick patients have been received in their foster homes and communities. A new, important ingredient seems to be the intensification of relationships within the smaller constellations in the foster homes. Those who tend to lose their identities in the larger setting of the institution seem to make better responses in less complex environments. For them, foster home care may be the best kind of continuing treatment.

[2] For these persons we may speculate that the known stimulating effect of change accounted for improvement. Change per se, however, could hardly account for the gains of the adjusted group, who showed sustained improvement for not less than two years from time of placement.

BY BARBARA M. HENLEY

Interprofessional Give-and-Take in Research on Patient Care

In 1958 a social worker in a large general medical clinic conceived and nourished the beginnings of a study on the psychosocial needs of a group of elderly outpatients. This paper reviews some of the interactions that took place in that clinic between the social worker and other researchers working in other disciplines. The emphasis is on the benefits and tensions arising from such contacts and the influences of other professions on a piece of social work research. These observations pertain largely to the preparatory stage of research; the study itself will not be described except as background for understanding this discussion.

THE SETTING AND THE STUDY

The milieu that nourishes a piece of research may have as much influence on the nature and methods of a study as the background of the investigator. In this case, the climate was set by the fact that numerous other professionals doing research within their own fields—doctors, nurses, sociologists, and statisticians—were brought together by a mutual conviction about the value of comprehensive medical care and by a common interest in the techniques of social research.

The general medical clinic is part of the comprehensive care and teaching program of a large eastern voluntary metropolitan hospital which contains a medical school and a school of nursing. The clinic gives service to some 2,000 patients and also provides training for fourth-year medical students. Five medical social workers cover this five-day-a-week clinic. The standard to which teaching and treatment aspire is to provide "a comprehensive, fully adequate continuing type of medical care which may be extensively copied on an economic and feasible basis and which might furnish the model for excellent care for all of the people." Research becomes an important part of such a setting in order to provide scientific bases for "excellent care" and to temper such care with deep understanding of human needs.

Since 1957 the program has committed itself to an intensive concern with research in the field of care for the chronically ill. Completed, or in progress, are such diverse studies as analyses of the electrocardiogram in cardiac hypertrophy, examination of certain laboratory factors in diabetes, collection of data by interview with so-called "troublesome patients," and analyses of social work referrals and services. There has been an intensive study of the role of the sick person in society. These and other studies have been conceived and carried out by individual doctors, nurses, sociologists, and social workers, each taking full responsibility for his own project but sharing his knowledge and problems with the other researchers in ways that will be described. Such an atmosphere induces the *service* personnel in the setting to develop the kind

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of objective awareness that permits one to examine the *what, how,* and *why* of care while care is being offered. This ideal is not foreign to social workers; most agencies require basic statistics which keep the worker aware of the broad scope and nature of her services. On a deeper level, the keeping of process records makes casework treatment a deliberate method based on the *what, how,* and *why* of the client's personal dynamics. After many years of casework practice in a setting where active exploration of patient care is going on, one becomes particularly thoughtful about what constitute needs and services.

Such thought prompted Doris Schwartz, a public health nurse and nursing co-ordinator in the clinic, to design a "Study of the Nursing Needs of Chronically Ill, Ambulatory Patients, Over 60, Attending a General Medical Clinic," using structured nursing interviews with a sample of 220 patients in order to collect her data. Previous small exploratory studies by Miss Schwartz had convinced her that there was a need for, and staff interest in, such a large-scale investigation of the subject. Her broad objectives were to determine the need for physical care, administration and understanding of medicines and treatments, and health education; data on human needs which are not now routinely given attention in the patient's record—such as baseline observations on the patient's daily activities, his work and recreational habits, eating and sleeping patterns, state of loneliness or companionship, range of interests; and knowledge and use of available community nursing resources.

Intrigued by the subject, the social worker began to speculate about the deeper *social and emotional* needs of this same group. Moreover, by completing social work interviews with the same 220 patients and designing a method of comparison with the nurse's activity, here was an opportunity to define the specific competencies within the nurse–social worker team. Thus was born "A Study of the Psychosocial Needs of Elderly Patients Attending a General Medical Clinic," as a supplement to the nursing study, both studies being made possible by a grant from the National Institute of Health. These were the aims of the social work study: to broaden existing knowledge about the social and emotional problems of this group, with specific concern for the areas of living arrangements, vocational adjustment, use of leisure time, financial adjustment, adjustment to illness, and morale and family relationships; to provide information as to areas in which a social work interview can isolate nursing needs appropriate for referral for nursing help; to define the specific competencies within the nurse–social worker team; to help determine whether a one-visit screening interview by a social worker is a desirable and practical technique in the care of all elderly, chronically ill, ambulatory patients.

BENEFITS AND CONFLICTS IN MULTIDISCIPLINE SETTING

From its inception, the social worker's ideas were shared with other researchers through informal consultation, circulation of progress reports and professional literature, and a weekly patient care research seminar. The latter group was composed of all the professionals doing research on the chronically ill within the comprehensive care clinic. Any member with a particular research problem or field of interest could request that a session be devoted to it. The agenda were circulated beforehand. The seminar might be led by an outside expert, by the person seeking help from the group, or by someone within the group with special pertinent knowledge of research methods, recent findings, or administration of a research program. Usually the curriculum for these sessions was steered by the sociologists, who had a wealth of background in social research. One session was devoted to a discussion of basic statistical tools using didactic teaching methods to convey the information. Another meeting was a work session

wherein the social worker's tentative questionnaire schedule was analyzed for content and approach, and suggestions gathered for its improvement. On still another occasion a doctor reported on the methods and findings of a health survey which was pertinent and stimulating to the group. These are samples of the kinds of programs that occupied the seminar. Every session was helpful, although the professionals were sometimes not completely at ease with each other's concepts and terminology. As has been found in at least one multidiscipline research setting, small groups with some leadership and other structural features, such as an agenda, seemed to make for most effective communication between the professions.[1]

STIMULUS TO EXAMINE BASIC CONCEPTS

It is toughening exercise for a caseworker to be confronted with such questions as "What is it that caseworkers really do in an interview?" "How do you know what is 'right' for a patient?" "How much of your helping process is based on intuition?" These and other questions were raised by the other toilers in the social arts and sciences in this clinic. Unlike the doctors and nurses, the sociologists here had relatively little experience with medical social workers. Their demands for a clearer understanding sprang from their desire to offer the most serviceable consultation. In order to bridge the gap of understanding, they were provided with typical case records. To make these even more dramatic, the worker held an unstructured intake interview during the pretests, before a one-way screen. The sociologists and the social statistician observed. In the discussion that followed, the social worker pointed out specific techniques that had been employed: handling the patient's feelings by simple recognition and acceptance; dealing with his specific anxiety before directing the interview toward the intake goal of gathering information; and enabling the individual to make a decision for himself about whether to take steps toward solving his stated problem.

There was disagreement among these professionals as to how hostility should be handled in a research interview. In the interest of a smooth flow of spontaneous information, the sociologists favored a fairly rapid fire of questions which would ignore signs of antagonism. The social worker found this kind of "third degree" directly opposed to some very basic convictions. It is an empirical concept of casework interviewing that hostility can be diluted by being put into words by the interviewer in a nonjudgmental manner. Furthermore, ours is a particularly ethical tradition which concerns itself with the *constructive* possibilities of a relationship—even the brief structured contact of a research interview.

To confirm this conviction the caseworker conducted a pretest interview with elderly, antagonistic Mr. L. He had earlier expressed his reluctance to "answer more questions about the same darn things I told the doctor fifteen times already." He was given only a brief interpretation of the purposes of the interview. The prestructured questions received superficial replies and the patient eventually withdrew into annoyed yes's and no's. In subsequent interviews the researcher introduced standardized interpretations into the questionnaire, in an attempt to alleviate some of the provocative aspects of the interview situation. For example, the use of the one-way screen in the room is explained as a "special kind of window . . . which enables another worker like myself . . . to help me take notes on our conversation. Does this trouble you at all?" The patient's reaction to this is handled before the interview proceeds. "We know it's hard for some people to talk about money matters. Would you mind telling us a little bit about . . . ?" has proved to be a softening introduction to questions about

[1] Robert C. Angell, "A Research Basis for Welfare Practice," *Social Work Journal*, Vol. 35, No. 4 (October 1954), pp. 145–148.

finances. At one point, well along in the interview, the questioner says, "I know this is quite a long interview and I want to thank you for spending this time with me. I have just a few more short questions you may answer in one word." This recognizes that fifty minutes of thought- and feeling-provoking questions have gone by; we appreciate their participation; what follows is brief and the end is in sight. Usually the respondent gets a "second wind" after this, and the interview is then completed more productively. The writer has since found recognition of this approach in the writings of several sociologists who are concerned with using interviews as a means of collecting data. Robert K. Merton, eminent professor, reseacher, and theorist, makes this statement:

> Under the conventionalities and courtesies of the interview situation informants will ordinarily not express accumulated hostilities, except through veiled aggressive statements, or, in extreme cases, through abrupt refusals to respond to questions. But when they see that the interviewer himself recognizes the possibility of these hostilities . . . [the] informants find a means of funneling off feelings of antagonism.[2]

Another sociologist and teacher, Lawrence Podell, suggests that

> emotion-alleviating items be included in the schedule and the testing of them be included as part of the pretest procedure of research.[3]

In other ways group discussions in the clinic helped the worker to cut through hazy working definitions and forced an examination of the values and fundamental assumptions upon which casework judgments are based. It was necessary to decide how much weight to give to the recorded verbatim replies of the patient and how much to the observed minimal physical reactions during an interview—which ordinarily tell a caseworker a great deal. One had to tangle with such evasive terms as *adjustment, need, ability to cope with problems,* and others. We use these terms in everyday practice. It was stimulating exercise to define them in ways meaningful to the profession and pertinent to the study. There were other problems. Should the study reflect the patient's estimate of need or the interviewer's opinion of the patient's situation? What areas should be explored to permit one to evaluate—even grossly—the total adjustment of the individuals in the sample? Past history? Current relationships? Degree of illness? State of employment? All of these—some in more detail than others? How can such a study make allowances for the differences in expectations which make some patients accept certain discomforts as their inevitable *status quo*? These and other problems were worked out under the helpful scrutiny of quizzical colleagues.

INFLUENCE OF SCIENTIFIC ORIENTATION

Descriptions of the nature of social work theory credit it with origins in the social and biological sciences, in Freudian psychology, and in creative intuition. All such definitions proceed to point out that a large part of our conceptual knowledge is based on practical experience. This part of our theory, plus intuitive judgments, is difficult if not impossible to classify and organize in a scientific manner. There are precedents in medicine, in sociology, and lately in nursing for ways of testing knowledge with a view to systemization. Such models left their imprint on the study. In particular the "Study of Extra Hospital Nursing Needs in Butler County, Pennsylvania" (1959, unpublished) by nurse Janice Mickey provided a method of summary which was adapted to the social work study. Miss Mickey provided an evaluation sheet which permitted

[2] Robert K. Merton, "Selected Problems of Field Work in the Planned Community," *American Sociological Review,* Vol. 12, No. 3 (June 1947), pp. 304–312.

[3] Lawrence Podell, "An Interviewing Problem in Values Research," *Sociology and Social Research,* Vol. 41, No. 2 (November-December 1956), p. 126.

the interviewer at the completion of an interview to check *area of need, intensity of need, patient's ability to cope with need,* and the *need for nursing activity.* To the definitions for a scale of intensity of need, the social worker added the dimension of patient's concerns with the need as one criterion of the strength of the problem. Another nursing concept from the Mickey study: *total level of functioning*—good, fairly good, fairly poor, and poor, was expanded to include, besides the number and intensity of the problems, some differentiation in the importance of the areas of the problem. In addition, evidence of problems or problem-solving abilities in the past was included to add up to some over-all picture of how well our patients are managing.

In problems of questionnaire construction, methods of drawing a representative sample, and techniques of data analysis, the social scientists contributed their sophisticated know-how. Specifically, they arrived at the size of a sample and produced a random list of names drawn from the clinic to ensure adequate representation of the clinic population; they drew up a tentative code to point the way for future statistical analysis of the data to be gathered; they made suggestions about the wording of specific questions, based on their knowledge of respondents' reactions; and suggested that some method be included in the study design which would provide a check on the validity of the interviewer's impressions—these suggestions led to the use of observers behind a one-way screen, described later in this paper. In general, the social scientists were standard-bearers for the criteria of reliability and validity.

The other investigators also helped to keep the research focus on the long-range goals of gathering general knowledge. It was difficult at first for the social worker to avoid lapsing into a therapeutic give-and-take in the interviews. It was hard to modify the individualized approach that characterizes casework, but the practical problems of dealing with a sample of two hundred persons made this necessary. The convictions of the other disciplines encouraged the worker to bear in mind the possibilities of ultimate benefits implicit in a study of needs. While undergoing this change in focus, it is helpful to be in touch with other investigators whose persistent interest is in generalizable rather than particular knowledge. Although there are generalizations implicit in much of what caseworkers do and say, we appear to individualize more than we generalize. Harriett Bartlett and William Gordon in their examination of the literature of medical social work are attempting to meet the need for "clearer identification of the knowledge [the profession] has so far put together for practice from all sources. . . ." [4] They feel that much of our implicit knowledge has been masked, if not actually buried, in descriptive, explanatory, practice-directive statements. The theoretical scientists, such as sociologists, appear to be more ready and willing to describe what seems to be *usually* the case as they have observed it. Social workers have an obligation to be similarly explicit about their knowledge.

Before deciding to employ a standardized questionnaire, the social worker discussed alternative methods of interviewing. Practice interviews tested varying degrees of permissiveness, ranging from an almost completely nondirective approach to the use of a check list to guide the areas of discussion. These methods were comfortable for a caseworker. All elicited problems and needs. The individualized method had unquestionable advantages for obtaining variety and depth of response. The disadvantages for this study, however, became obvious: the problem of analyzing such a bulk of informal responses in a meaningful way; the problem of arriving at valid quantifiable findings; the problem of achieving complete

[4] William E. Gordon and Harriett M. Bartlett, "Generalizations in Medical Social Work: Preliminary Findings," *Social Work,* Vol. 4, No. 3 (July 1959), p. 72.

coverage of all topics with sufficient range and specificity of reply for each topic. With consultation from sociologist colleagues, a standardized questionnaire was finally constructed and pretested. It retains the character of its parent in several important ways, among them the use of so-called "open-ended" questions that preserve the conversational approach and permit spontaneous expression of feeling ("Do you have difficulties managing on your income? Where do you feel the pinch the most?" seems preferable to such structured queries as "Is it hard for you to afford the following: food? rent? clothes?" or the like). Also retained was the use of diagnostic impressions based on material gleaned in the interview and from the medical record, and the use of fundamental social work concepts in the basic content of the questionnaire—such as the impact of past adjustment on today's capacities, and the importance of the patient's feelings about his situation as a criterion of disability.

One other element in the study design illustrates the influence of association with scientific precedents. In order to assure some measure of reliability and validity in the social worker's impressions, it was decided that 10 percent of the interviews would be observed and recorded by other social workers using the one-way screen. If the judgments of the viewer as to the presence of need, intensity, and patient's ability to meet the need or his readiness for social service referral—if these judgments agreed largely with those of the interviewer, one might assume that such evaluations represented professional statements based on a common body of knowledge and not solely on the personal standards of a unique individual—*i.e.*, the interviewer. It was natural to entertain the idea of employing such a check, since in a medical setting the screen is commonly used for both teaching and research. Doctors in this setting were asked about their experience with the screen. Some usually informed the patient that he was being observed and explained why. Some did not. All doctors agreed that they had never found a patient to be resistant or particularly self-conscious in the room with the screen. With the feeling, expressed by Dorothy Beck in a recent issue of *Social Casework*, that the time has come for bolder methods of validating our techniques,[5] this kind of observation was adopted. With traditional regard for what is being *done to* the client, each patient was made aware of the possibility that the interview might be watched, and opportunity was made for the patient to react. (In twenty-five such interviews to date, only one patient showed any reaction beyond mild curiosity. There are indications that respondents forget the existence of the screen early in the interview.)

BROADENING GOALS

A caseworker working as a member of a medical team consciously or unconsciously adopts some of the values of the helping professions around him. Note should be taken here of the difference between *research* in a multidisciplinary medical setting and the familiar "team approach" toward *service*. In the traditional team, the members act as consultants and co-workers, assuming shared responsibility for the problems of the patient. But here the "problem" is not a client's welfare, but rather the designing of a study, and the collection, analysis, and interpretation of data. Solving this problem rests with the principal investigator, in this case a caseworker turned researcher. Used to close supervision and shared responsibility in the past, one may feel anxiety at first. But this can be a maturing experience as the study takes shape and the worker begins to sense a new self-confidence. It is vital that the worker continually sharpen the validity of his research against the practical experiences and judgments of his own profession. This is particularly true in a multidisciplinary setting. "Professional fall-

[5] Dorothy F. Beck, "Potential Approaches to Research in the Family Service Field," *Social Casework*, Vol. 40, No. 8 (August 1959).

out" from the other disciplines can distort the methods and philosophy peculiar to social work. Social workers would not attempt to take a detailed diet history or offer a complicated medical interpretation, even though hospital work gives us some familiarity with these skills. Similarly we must not lose our appreciation for the uniqueness of an individual's capacities and demands, even though we come to share the social scientists' interest in aggregates. The social work researcher in a multidisciplinary setting—indeed, in any setting—should use consultation with members of his own profession as one method of preserving what is distinctive and valuable in social work.

One of the goals of the studies of *nursing needs* and *social needs* is to identify those areas in which each professional interviewer can most reliably locate problems appropriate for referral to the other discipline. These definitions of social and nursing needs proved somewhat arbitrary. The nurse and the social worker came to think rather of *patients' needs,* the legitimate concern of all members of a team, whether providing service or studying the need for it. The social work interviewer in this project became alert to a broad range of problems not traditionally treated by the medical caseworker, but certainly affecting his total adjustment and requiring referral. For example, in evaluating the need for referral to another discipline, the researcher might feel that Mrs. T could be taught to meet her nutritional needs better through discussion with the nurse of food management on a welfare budget. Or frail Mrs. P, living alone, might have her diabetic techniques supervised more closely between clinic visits by a visiting nurse. Or might not the physical therapist show arthritis-racked Mr. R new ways to dress himself, instead of continuing to depend with embarrassment on his daughter's daily help? Such considerations enable the researcher to embody the concept of comprehensive care within the limits of a social service study.

When considering the opportunity for broadening of goals, one realizes that traditional social work concepts may help to expand the horizons of the other researchers in the multidisciplinary setting. A social worker has specific knowledge of how the hospital-patient relationship can affect the patient's feelings about his disease, and even about himself as a person. The worker is particularly aware of the need to individualize patients. He has given thought to the patients' expectations of the white-coated hospital hierarchy. Like the doctor and the nurse, he knows from long contact with these ailing people the easy fatigue and daily pain that many carry with them, and thus becomes spokesman for protection of the emotional as well as physical welfare of the patient in the research setting. As a result of this point of view, great pains were taken by all the researchers to keep interviews brief and explanations to the patient full and tactful; the patient care research group also adopted a system of labeling medical charts with the date and nature of any study done—thus the patient may not be overexposed to interviews, tests, or questions, and each researcher can better interpret the respondent's reactions to the study procedure at hand in light of previous contacts with other investigators.

Within the design of every study under way are incorporated features that aim to elicit the patient's co-operation and spare him as far as possible any physical or psychological discomfort. Several examples from the social service study show this principle in action:

1. By defining different orders of intensity of need, those regarded as "critical" may be immediately discussed with the patient's doctor with an eye to meeting the problem.

2. Both in the questionnaire and in the manual of instructions that accompanies it, there are devices for permitting the patient to let off steam or give vent to feelings about a particular question. (As noted on p. 94 about use of the one-way screen, "Does this trouble you in any way?" Or, "We know many people don't like to talk about their

money matters. Anything you tell us will not be used for any purpose outside of this study." Or, "How do you feel about this interview?" and so on.)

3. Provision is made for conducting the interview in two half-hour sessions during consecutive clinic appointments if the full hour interview seems to be tiring.

SUMMARY

A setting in which research is carried on is likely to stimulate even the service-oriented worker to a more objective awareness of the job being done. Once a social worker undertakes research in a multidisciplinary setting there is much to be gleaned from the other professions and the channels of communication should be kept open. The most workable method of sharing in this clinic seemed to be through small structured seminars. Interpretation of social work goals and methods may be offered to other disciplines by providing case material or interviews before a one-way screen and then discussing the techniques illustrated.

The worker found conflicts between traditional casework techniques for handling feelings during an interview and the demands of a standardized research approach. This was partially resolved by building into a questionnaire various hostility-reducing items.

The presence of interested and quizzical colleagues from other disciplines stimulated the worker to examine closely and attempt to define many of the implicit concepts that underlie the field of casework.

The contact with scientifically oriented professions was specifically beneficial in other ways: in providing models for social work studies, in emphasizing the value of generalizable knowledge and in emphasizing criteria of research reliability and validity, and offering devices for insuring this. One method for insuring worker reliability that seems practical is recorded observations made by workers watching interviews before a one-way screen. Such records may then be compared with those of the interviewer.

Interprofessional interaction during preparation for a study of patient's needs resulted in a broadening of goals for all. The social worker brought to the setting a tradition of humanitarianism and awareness of what is being done to the respondent in an interview. The other professions widened the worker's understanding of needs and how they may be met. They also helped the worker toward a more sophisticated grasp of research know-how.

BY MINERVA G. COLE AND LAWRENCE PODELL

Serving Handicapped Children in Group Programs

THE DEMONSTRATION PROJECT on Group Work with Handicapped Children was sponsored from 1955 until 1958 by the Community Council of Greater New York.[1] It was concerned with demonstrating how handicapped children could be incorporated into the group work programs of neighborhood centers. Most of the handicapped who participated were victims of orthopedic impairments.

Some of the problems involved are familiar to all group workers: they have to do with staff, program, budget, referral. Other problems relate to the fact of the children being handicapped: maintenance of liaison with medical, educational, and other social agencies; transportation difficulties, parental attitudes, reactions of the handicapped children to inclusion in the program, and reactions of nonhandicapped children to the new members.

The project staff and the staffs of co-operating agencies accumulated experience in solving these problems. But to demonstrate that effective programing could be accomplished for orthopedically handicapped children was but a means to an end. The long-range objective of the project was to motivate personnel of many agencies to begin their own programs in this field. The experience accumulated would be of limited value unless it could be used by creators of new programs.

SURVEY

In the third year of the project it was decided to survey the attitudes of directors of group work and recreation agencies in New York City toward serving the handicapped. In essence, this was an attempt to gain some insight into what we were up against when it came to motivating directors to incorporate these children into their agencies. What did they think—and what did they know—about programing for orthopedically handicapped children?

In January 1958 the first wave of mail questionnaires was sent out. It was followed in February by a second mailing to nonreturnees. Of the 206 directors on the mailing list, 90 returned usable questionnaires.[2] The sample should not be considered representative, since those with greater interest or experience with the handicapped were probably more prone to reply. But when appropriate cross-tabulations are performed, some meaningful relationships appear.

Of the directors who replied, 72 percent had had professional experience dealing

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[1] This project was financially supported by grants from the Association for the Aid of Crippled Children, the Ray Charles Newman Foundation, the Nathan Hofheimer Foundation, and the Crippled Children's Friendly Association. See *We Can Be Friends* (New York: Community Council of Greater New York, 1959).

[2] Their names were obtained from two sources: the *Directory of Social and Health Agencies of New York City, 1956–57,* and a listing of community centers in public housing projects in New York City.

TABLE 1. KIND OF AGENCY SUGGESTED BY DIRECTORS TO SERVE HANDICAPPED CHILDREN

	Directors' Prior Professional Experience with Children					
	Handicapped		Orthopedically Handicapped		Cerebral Palsied	
	Experience	No Experience	Experience	No Experience	Experience	No Experience
	Percent		Percent		Percent	
Existing agencies	61	32	67	36	69	36
Specialized agencies	17	52	13	43	6	43
Both	20	4	18	13	22	13
No answer	2	12	2	8	3	8
	100	100	100	100	100	100

with handicapped children. Half reported experience with the orthopedically handicapped and 38 percent with the cerebral palsied.[3] How does the factor of the directors' previous experience with the handicapped affect their suggestions for serving handicapped children?

KIND OF AGENCY

Of the directors with prior professional experience with handicapped children, 83 percent had such children presently participating in their programs, as against only 28 percent of the directors without previous experience. Seventy-one percent of the directors with prior experience with orthopedically handicapped children reported such children in their agencies, while a mere 20 percent of the respondents without previous experience included them. While 78 percent of the directors with prior experience with cerebral palsied children said that such children were participating in the agency, only 7 percent of the respondents without experience reported their inclusion. It is clear that the previous experience of directors with handicapped children was positively related to the inclusion of these children in their agencies. Conversely, directors without prior experience tended to report the absence of such children from their programs.

When the directors were asked, "In your opinion, should there be special group work agencies for the handicapped or should the handicapped be included in the programs of existing group work agencies?" a majority—53 percent—checked "existing agencies," 27 percent wrote "special agencies," 16 percent said "both," and 4 percent did not answer. Prior professional experience with handicapped children was an important factor in the choice. In Table 1 the respondents' answers are tabulated by their experience and lack of it. Whether their experience was with the handicapped in general or, more specifically, with orthopedically handicapped or palsied children, most directors with prior experience thought that existing agencies could do the job. Those lacking such experience showed a greater tendency to suggest specialized agencies.

[3] Throughout the questionnaire, separate but identical questions were asked about the orthopedically handicapped and the cerebral palsied. While some respondents viewed cerebral palsy as merely one of the many kinds of orthopedic impairments, a substantial number treated the palsied as quite distinct from those with orthopedic difficulties. Medically speaking, children with orthopedic impairments include those with congenital malformations and such acquired disabilities as are caused by accident, amputation, and disease (including victims of poliomyelitis, muscular dystrophy, Parkinsonism, and cerebral palsy), but in practice the cerebral palsy group is often seen as distinct. Since our questionnaire made room for the distinction, this paper will reflect it.

TABLE 2. DEGREE OF DIFFICULTY ANTICIPATED BY DIRECTORS IN INCLUDING HANDICAPPED CHILDREN

If Orthopedically Handicapped Children Were Included	Directors' Prior Professional Experience with Children			
	Handicapped		Orthopedically Handicapped	
	Experience	No Experience	Experience	No Experience
	Percent		Percent	
None or minor	60	32	67	35
Major or prohibitive	29	52	29	46
No answer	11	16	4	19
	100	100	100	100
If Cerebral Palsied Children Were Included	**Handicapped**		**Cerebral Palsied**	
	Experience	No Experience	Experience	No Experience
	Percent		Percent	
None or minor	42	24	65	26
Major or prohibitive	43	60	22	59
No answer	15	16	13	15
	100	100	100	100

Respondents were asked to write in their reasons for choosing existing or specialized agencies. Existing agencies were chosen: for "practical reasons" (*e.g.*, convenient location of neighborhood agencies); because they would foster the "social development of the handicapped child" (for example, learning how to live with his nonhandicapped peers); for the "psychological development of the handicapped child" (*e.g.*, less reinforcement of self-centeredness, self-pity); and for the "social development of the nonhandicapped child" (for example, learning how to live with people different from himself). Specialized agencies were recommended: for "practical reasons" (*e.g.*, matters of equipment, staff training, special care); because they would aid the "psychological development of the handicapped child" (for example, by not being reminded that he is different or less capable); for "policy reasons" (*e.g.*, the character of the existing agency would be changed by including the handicapped); and for purposes of "temporary adjustment" (for example, until the child is oriented to group activity).

Directors with prior experience and those without it alike gave "social development of the handicapped child" as the most frequent reason for choosing existing agencies to serve the handicapped, and to about the same extent. This is to be expected in light of their commitment to the group work field. However, 48 percent of those without prior professional experience with the handicapped, as against only 14 percent with such experience, offered "practical reasons" for selecting specialized agencies. Though the questionnaire said, "In answering, please assume that the handicapped children to which we refer are ambulatory and without extreme behavior problems," respondents without previous experience with the handicapped seemed to find it difficult to think of the handicapped in less than severe terms. Their major reason for choosing specialized agencies for handicapped children concerned what they assumed to be the needs for special personnel, unique facilities, and unusual programs.

DEGREE OF DIFFICULTY ANTICIPATED

Respondents were asked: "If orthopedically handicapped children were included in your agency's program, what degree of difficulty would you anticipate?" Most of the directors with prior professional experience

with handicapped children anticipated "no difficulty" or checked "minor adjustments," while those without such experience tended to foresee "major revisions" or "prohibitive difficulties" or gave no answer (*see* Table 2). The next item on the schedule repeated the question but referred to cerebral palsied children. Again, directors with prior experience were more likely to anticipate little or no difficulty including these children.

While the assertion "if the director has had previous experience, he tends to anticipate less difficulty at inclusion," is supported by the data concerning both the orthopedically handicapped and the cerebral palsied, there were differences of degree in the reference to one as compared with the other. As may be seen in Table 2, whether the prior experience was with the handicapped generally or the orthopedically handicapped specifically did not make much difference in the degree of difficulty expected if the orthopedically handicapped children were included. But whether the experience was with the handicapped generally or with the cerebral palsied in particular did make a difference in the degree of anticipated difficulty if palsied children were included. The items followed one another in the questionnaire. They were constructed identically. Respondents could have easily answered both in the same way without much thought. But the response percentages do differ. Previous experience with the handicapped in general seems to prepare directors better for the inclusion of the orthopedically handicapped than for the inclusion of the cerebral palsied.

BUDGETARY INCREASES

After each of the questions concerning the anticipated degree of difficulty, respondents were asked to write in the particular diffi-

TABLE 3. ADDED OR INCREASED BUDGETARY ITEMS ANTICIPATED BY DIRECTORS IF HANDICAPPED CHILDREN WERE INCLUDED

	Directors' Prior Professional Experience with Children					
	Handicapped		Orthopedically Handicapped		Cerebral Palsied	
	Experience	No Experience	Experience	No Experience	Experience	No Experience
	Percent*		Percent*		Percent*	
None	5	4	4	5	3	5
Special Costs To Be Added						
Caseworkers	20	40	18	36	12	36
Nurses	17	40	15	33	6	33
Different intake procedure	29	32	22	36	25	36
Special athletic facilities	35	68	35	59	28	59
Elevators or ramps	51	44	53	49	37	49
Special transportation	55	60	58	54	56	54
Existing Costs To Be Increased						
More group workers	75	88	75	84	68	84
Increased supervision	75	72	73	74	72	74
Additional records	55	52	53	51	50	51
Additional insurance	44	52	46	49	34	49
Average no. of items mentioned	4.6	5.5	4.5	5.3	3.9	5.3

* Because the respondents could check as many answers as they chose, the percentages in each column total far in excess of 100.

TABLE 4. SOURCES OF ADDITIONAL FUNDS SUGGESTED BY DIRECTORS

	Directors' Prior Professional Experience with Children					
	Handicapped		Orthopedically Handicapped		Cerebral Palsied	
	Experience	No Experience	Experience	No Experience	Experience	No Experience
	Percent*		Percent*		Percent*	
The agency itself	46	40	49	36	53	36
Disease or disability organizations	57	68	60	59	53	59
Individual or parent	35	32	38	31	31	31
School system	17	12	18	13	25	13
City departments	31	24	33	23	25	23
Average no. of sources mentioned	2.0	1.8	2.1	1.7	2.0	1.7

* Because the respondents could check as many sources as they chose, the percentages in each column total far in excess of 100.

culties they would anticipate. Most of them mentioned facilities (equipment, plant, staff, programs) of one sort or another.[4] Facility lacks can be overcome by increased expenditures: equipment and space can be rented or bought, personnel can be hired or trained, and—combining the two—programs can be developed. The directors were asked, "In your opinion, which budgetary items would have to be added or increased if handicapped children were included in your program?" Table 3 shows how their prior experience affected their responses.

Concerning items which entail qualitative changes—that is, new and somewhat different expenditures for group work and recreation agencies—the directors without prior experience with the handicapped saw a much greater need for caseworkers, nurses, and special athletic facilities. The two groupings showed similar (and quite realistic [5]) views regarding special transportation. Regarding budgetary items that necessitate quantitative changes—that is, more money for usual expenditures—the two groupings show similarities, with slightly greater tendencies for the inexperienced directors to desire more group workers and additional insurance.

Where should the money come from to pay for added costs? The directors were asked this question, and in Table 4 their responses to it are tabulated by their previous experience with handicapped children. Those who had prior professional experience with the orthopedically handicapped or the cerebral palsied were more likely to check "the agency itself, as part of its function" than were directors without experience.

PARTICIPATION OF THE HANDICAPPED

Lack of facilities was only one of the difficulties anticipated by directors if handi-

[4] Referring to the orthopedically handicapped, 65 percent wrote of facilities, 20 percent of reactions of the nonhandicappped, 7 percent of reactions of the handicapped, 10 percent of nonparticipation of the handicapped, while 13 percent did not answer or did not know. Referring to the cerebral palsied, the percentages were 51, 21, 6, 9, and 24, respectively. We may suggest that the lesser proportionate mention of facilities when referring to the palsied is a matter of higher incidence of ignorance (more "don't know" replies or lack of reply).

[5] See *We Can Be Friends, op. cit.*, p. 23–24 and Alfred D. Katz, *Study of Transportation for the Handicapped in New York City* (New York: Community Council of Greater New York, 1954).

TABLE 5. DIRECTORS' VIEWS OF EXTENT OF POSSIBLE PARTICIPATION OF HANDICAPPED CHILDREN

Orthopedically Handicapped Children	Directors' Prior Professional Experience with Children			
	Handicapped		Orthopedically Handicapped	
	Experience	No Experience	Experience	No Experience
	Percent		Percent	
Prohibitive limitations	3	4	2	5
Some limitations	68	76	69	78
Few or no limitations	20	8	22	7
Don't know or no answer	9	12	7	10
	100	100	100	100
Cerebral Palsied Children	**Handicapped**		**Cerebral Palsied**	
	Experience	No Experience	Experience	No Experience
	Percent		Percent	
Prohibitive limitations	5	12	3	12
Some limitations	54	48	56	54
Few or no limitations	18	8	25	10
Don't know or no answer	23	32	16	23
	100	100	100	100

capped children were included in their agencies' programs; lack of participation in activities by the handicapped was another (see Footnote 4). Respondents were asked, "Of the activities in your program, in which do you think the orthopedically handicapped could not participate?" An identical question followed concerning the cerebral palsied. Their replies were categorized under three headings: (1) so limited as to prohibit participation; (2) limited participation is possible (for example, in choral singing but not in dancing or athletics, or as spectator participants but not active participants in arts and crafts or cooking); and (3) few limitations (which could be overcome) or complete participation. In Table 5 the directors' previous professional experience is related to their opinions about the extent of possible participation of orthopedically handicapped and cerebral palsied children in programs of their agencies. The table shows that experienced respondents tended to see fewer limitations. The higher incidence of "don't know" or "no answer" responses when the question concerned the cerebral palsied specifically seems to indicate greater ignorance of the varieties of the condition and the potential abilities of victims of the disease.[6] Group leaders of the Demonstration Project reported their own experience in this regard as follows:

> Often [the children] modified games and other activities so that they could all participate regardless of the degree of physical involvement.
>
> At no time did the group leader feel that programing for this group was any different from programing with any other type of group.

As we have seen, directors without prior professional experience with the handicapped not only anticipated a greater degree of difficulty than their experienced

[6] When the question referred to the orthopedically handicapped, 3 percent of the respondents mentioned that the children's participation would be so limited as to be prohibitive. 70 percent wrote of some limitations, 17 percent mentioned few, if any, and 10 percent did not know or did not answer. The percentages when the question concerned the cerebral palsied were 7, 52, 16, and 25. As suggested in Footnote 4, ignorance about the palsied is apparently greater than about the orthopedically handicapped.

colleagues if these children were included in their programs, but also differed on the "best method of including the handicapped" in programs. As may be observed in Table 6, the inexperienced directors were more likely to suggest that, if included, the handicapped be kept in all-handicapped groups and/or separated from nonhandicapped children in the agency. On the other hand, the directors with prior experience showed a greater tendency to suggest integrating on an individual basis. Perhaps this demonstrates that with experience comes the recognition that there are different kinds of handicaps, with varying degrees of severity and psychosocial problems and varying degrees of acceptance among the nonhandicapped—who have their psychosocial problems, too.

SUMMARY AND INTERPRETATION

The attitude of inexperienced directors toward the treatment of the handicapped bears some similarity to the attitudes toward the treatment of minority groups. First, there is the stereotypical characteristic of the attitude. From their prior lack of contact, the directors without experience are unaware of the capacities of the handicapped—especially the cerebral palsied. The handicapped tend to be viewed as a category without shadings, without varying degrees of physical abilities and emotional problems, and as different in kind—not degree—from the nonhandicapped.

It is true that orthopedically handicapped and palsied children are hindered, to greater or lesser extent, in their physical mobility (with a consequent lack of prowess in *some* games, sports, and crafts). But are there not nonhandicapped children who, because of being underweight, overweight, or muscularly underdeveloped, are in almost the same position as regards program? Some handicapped children, indeed, lack certain traits of sociability because of frequent prolonged hospitalization or homebound schooling—but are there not nonhandicapped children lacking these same traits because of other circumstances? A few handicapped children develop severe psychic problems, but such problems are hardly limited to those with ambulatory or agility difficulties. In other words, the difficulties of programing to meet the psycho-social-

TABLE 6. METHOD OF INCLUDING THE HANDICAPPED SUGGESTED BY DIRECTORS

	Directors' Prior Professional Experience with Children					
	Handicapped		Orthopedically Handicapped		Cerebral Palsied	
	Experience	No Experience	Experience	No Experience	Experience	No Experience
In Groups of All-Handicapped Children	Percent		Percent		Percent	
Kept separate from others	5	16	2	13	3	13
Participating with others	5	8	2	10	3	10
In Mixed Groups						
Kept separate from others	2	4	2	3	3	3
Participating with others	13	12	11	13	16	13
Integrate on individual basis	59	48	70	48	56	48
Other and no answer	16	12	13	13	19	13
	100	100	100	100	100	100

physical needs of handicapped boys and girls are not qualitatively different from those usually encountered by group work agency directors. Yet those without prior experience with the handicapped tend to view them stereotypically as a separate category of human beings, needing all sorts of special and expensive facilities and unusual and expensive care.

Second, there is the segregationist aspect of the attitude. Whether in separate agencies or in separate groups or programs within agencies, inexperienced directors are more prone to keep the handicapped and the nonhandicapped apart. To some extent this is a result of the stereotype of the handicapped. However, inexperienced directors also mention such reasons (all too familiar in other contexts) as protecting the handicapped from exposure to unfair competition, and from rejection and abuse by the nonhandicapped; they also suggest keeping the handicapped by themselves so as to be free to develop to their own fullest capacities. Not only does this assume that so-called "normal" children will be unusually cruel to those with handicaps—an assumption which the Demonstration Project discovered to be unfounded—but even if this were true, we must recognize that the mildly handicapped may be just as cruel to the severely handicapped as the nonhandicapped could be. In addition, development to fullest capacities entails learning to live in a realistic world, one populated by the nonhandicapped in the main.

The experienced directors apparently know this and are more likely to view the handicapped child as an individual, with program problems that differ somewhat in degree from those for other children. These directors apparently believe that the handicapped child, with some orientation and adaptation, can be included in the groups and activities of local agencies.

We cannot assume that inexperienced directors will undergo a change in their stereotypical or segregationist attitudes as a matter of course in their professional development. Our data show that those without prior experience with the handicapped tend not to seek out such experience in their later careers. The prejudgments which have limited their contact continue to do so. These prejudices may be reduced by demonstrable facts—as this Demonstration Project has attempted—and by the prescribed inclusion of contacts with the handicapped as part of their professional school training. Those involved with social work education should find this worth considering.

BY STANLEY BERGER

Casework with the Nonattendant School Child

THE SCHOOL IS a social institution with which all people have had some experience. It is authoritative and compulsory in its very nature, requiring not only regular attendance but also reasonable academic and social achievement. School standards and controls are formulated for the welfare of the individual as well as the group. The requirement of compulsory attendance at school of all youngsters between certain ages is but one of the limits set down by society in the interest of the individual child and the community.

Historically we note that from the inception of organized educational systems regular school attendance was considered essential. The philosophy of attendance enforcement has changed, however, from "You *must* attend!" to "What is *preventing* you from attending and how can we *enable* you to attend?" Another major advance has been acceptance of the fact that excessive school absenteeism is symptomatic of maladjustment, that it often precedes delinquency, and that it is advisable to help the child in the incipient stages of nonattendance in an effort to prevent further disorganization and more serious deviant behavior.

The school social worker, in his work with children and parents, is identified with and represents the authority of the school. He often uses this authority as a tool in the treatment of children who manifest their problems through school absenteeism. Although we all have some negative feelings about authority, the positive use of it is a necessary ingredient in the growth process. It sets reasonable limits on behavior and often reduces conflicts in children and adults.

THE SCHOOL NONATTENDANT AND MULTIPROBLEM FAMILIES

As school systems worked with absentees, they found that there was a group of children who were in need of the skilled handling of school social workers.[1] These were youngsters who came from multiproblem, hard-to-reach families. Practice has shown that the authoritative aspect of attendance work is particularly effective with such families, whose patterns have been to withdraw or reject voluntary referral.

Some of these families become known to voluntary agencies when a crisis situation develops and they are able to muster the strength to seek help. However, many lack the motivation or willingness to continue casework contact after a few interviews. The voluntary agency, therefore, closes its case. Still other families never do get to the community agency. They are in need of casework treatment which is unavailable to them *because* of their problems.

The school children in these families are necessarily deeply involved in their home problems and react to them in an unhealthy way. They may remain out of school for extended periods of time. They usually are or become academically retarded. Reading and arithmetic abilities fail to progress with chronological age and may adversely

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[1] This title varies with the school system—the term used may be *attendance teacher, visiting teacher, home-school counselor,* or the like.

affect grade placements. The children's problems may manifest themselves in either generally overaggressive or withdrawn behavior. They may be overdependent or hostile with their teachers and other authority figures in the community. New approaches and techniques are being developed, so that these children can be reached and given the necessary assistance.

Past negative experiences tend to make people fearful of being declared incompetent and being rejected. Hard-to-reach families are often fearful, hostile, resistive, and poorly motivated. Parents and children distrust the society that has pushed them or allowed them to slip into their entanglements. They are truly in need of a social service which they will not secure for themselves. Society, therefore, must assume the responsibility of attempting to give assistance where a great deal of resistance will initially be met. The problems encountered in establishing a relationship with resistant clients are casework problems for which solutions are being sought. Several articles have been written in recent years which give social workers greater insight into the needs of highly resistive clients and the changing role we must assume in order to help them.[2]

REACHING OUT TO THE HARD-TO-REACH CLIENT

The school social worker is in a most unique and advantageous position in bringing the helping service to the involuntary client. He has a natural entry into the home in that most people recognize his right, even if not openly acknowledged, to be in a problem situation. He is further strengthened through community acceptance of the authority inherent in the school structure—the teacher being considered *in loco parentis*—and the compulsory education laws. The authority inherent in the school, therefore, helps parents with their ambivalent feelings about securing help, since it serves to resolve conflicts they may have around acceptance or nonacceptance.

The hardest task the school social worker is called upon to accomplish is the establishment of a working relationship. He uses the home visit as an aid in reaching out to the client. The home is a less threatening setting for parents, since they are in a familiar environment which affords them much more security and ease than a strange agency office. If during an interview they should feel threatened, they can go to the kitchen "to shut the stove" or "open a window" and then return to the worker—the home affords them a certain amount of freedom of movement for which they do not have to fear rejection.

The school social worker is given the opportunity of seeing the physical condition of the home. Observations of the furnishings and tidiness of the home help in assessing parental roles. The worker is often able to study family member interrelationships at first hand. He sees them in action. The unstructured and informal setting usually permits parents and children to resume their normal patterns of behavior after the worker has visited several times.

School interviews serve to bring the social service to the child. Many children are familiar with the school social worker because they see him in the school and the neighborhood. This identification usually helps the child to accept the request that he come to the worker's office for a talk. In most cases, the youngster has already been prepared for the interview by his parents. Planned weekly home and school visits are necessary for an extended period of time.

It is vital that the worker show the client

[2] Lionel C. Lane, "Aggressive Approach in Preventive Casework with Children's Problems," *Social Casework*, Vol. 33, No. 2 (February 1952), pp. 61–66; Charlotte S. Henry, "Motivation in Non-Voluntary Clients," *Social Casework*, Vol. 39, No. 2–3 (February-March 1958), pp. 130–136; Ruth Ellen Lindenberg, "Hard To Reach: Client or Casework Agency?" *Social Work*, Vol. 3, No. 4 (October 1958), pp. 23–29; Berta Fantl, "Integrating Psychological, Social and Cultural Factors in Assertive Casework," *Social Work*, Vol. 3, No. 4 (October 1958), pp. 30–37; Walter Haas, "Reaching Out—A Dynamic Concept in Casework," *Social Work*, Vol. 4, No. 3 (July 1959), pp. 41–45.

that he is an accepting person who is genuinely interested in helping the family. Many clients test the worker to see if they will be rejected. Others use this device as a method of provoking this uninvited visitor to break contact with them. The role of the worker is extremely difficult during this period, since he must accept parents and children without condoning their behavior if it is in any way antisocial.

Although the school social worker may find many problems in a home situation, he must place priorities on certain needs and wait a period of time before he can or does handle others. He must first attempt to meet the pressing concrete needs of the family. This may involve consultations with welfare agencies to obtain school clothing, restoring gas or electric service, or readjustment of a welfare budget. As the clients see that they are receiving some material gains and appreciate the removal of some real pressures because of the worker's presence, resistance begins to ebb. Slowly they begin to trust *their* worker and eventually look forward to their next meeting with him.

In many instances, client dependency needs are met by the worker. This often involves doing things, such as making appointments with health and welfare agencies, which should ordinarily be done by the client himself. With the conscious use of himself and the necessary awareness not to give active encouragement to overdependency, the worker uses support, encouragement, and clarification as techniques for adjustment.

CHILD-FOCUSED, FAMILY-CENTERED CASEWORK

The greenhouse where attitudes are planted, nurtured, and grown is the home. From infancy the child experiences the feelings of satisfaction, pain, security, fear, love, and hate. As he grows older, his sphere of interrelationships widens to include other children and adults. But the school child, after having played on the streets, must return to his home. He must rely upon his parents for physical and emotional security. In addition to love and acceptance he is also in need of parental motivation and proper direction.

As the school social worker establishes a relationship with the parents and they accept the worker and his role, parental attitudes toward the child and school attendance become more positive. This change is noted with both the unlawfully detained and the truant child. The parents show increased interest in their youngster's school adjustment and begin to take a more positive role in helping the situation.

The importance of involving fathers in working with attendance problems has become increasingly evident. From our experiences we find that mothers frequently withhold information from their husbands. Some feel that, since they are at home with the children most of the day, it is their responsibility to handle them. They may feel that they have failed in their mother role if they openly discuss this problem with the father; many fathers concur in this. It is interesting to note, however, that the authority vested in the school social worker, when he sees the father and apprises him of the situation, mobilizes him to immediate action which he might not take were he seen by a voluntary worker. In some instances the father may be too ineffectual or passive to assume his role. But the mother is usually relieved when the other parent is involved.

This child-focused, family-centered approach in no way precludes the possibility of working with children with little or no parental involvement. Despite our experiences in some cases where parents were unable to involve themselves, much has been accomplished by working almost exclusively with the nonattendants. Although this is a difficult task with extremely young children, marked gains have been made with youngsters in early adolescence and adolescence. As long as these parents do not strike out at

the children because of their youngsters' involvement with the worker, there is hope for adjustment.

Since there often exist a great many interpersonal conflicts in these home situations, and the school social worker works with several family members, he must be careful to avoid overidentification with any one member of the family, with resultant feelings of rejection by the others. He must be sensitive to parental fears of being stripped of role and authority. The goal of the worker is to strengthen the intrafamilial ties and parental roles, not to weaken them.

Working with the multiproblem, highly resistive family is a slow, long-term process. It takes a great deal of time to work through client resistance and then proceed to help adjust their many problems. Although it is difficult to set down a prescribed time limit for a case, a minimum of one year's treatment is usually needed.

The authority mandated by compulsory education laws carries with it an obligation on the part of the worker to bring about results which are not inconsistent with the demands of society. Occasions arise when the authority of the court must be employed to protect the right of the child and the community. There are times when, early in the worker's contacts with a child and his parents, it becomes evident that the authority vested in the court would help the family to mobilize itself and begin to change. Court referral may thus come early as a method of motivating and stimulating client movement. Surprisingly enough, such a referral often enhances the client-worker relationship. Clients need to be prepared for the referral in terms of the reasons for it and what can be gained by it. The worker plays an extremely important supportive role prior to, during, and after the referral.

Adequate psychiatric consultation time must be allotted to the worker. In addition, he must be assured of close collaboration with school personnel and community welfare agencies.

CASE ILLUSTRATION

The following illustration serves to point up the kinds of problems met by the school social worker and the services of adjustment he renders.

Joseph Stern, a youngster in early adolescence, was referred for intensive casework services. Although this boy had maintained a poor attendance record throughout his school history, his attendance showed marked deterioration during the previous two years. Last year, he started acting out in school, received a *C* in conduct, and failed all his major subjects. As a result he was held over in the seventh grade. Many of Joseph's absences had been attributed by his mother to illness, with a major number explained as stomach upsets. The family had been previously referred to the local mental hygiene clinic, but the referral was refused by the parents.

During the school social worker's earliest contacts with Mrs. Stern, she verbalized willingness to work with him in the interest of her son. She recognized that the boy was having some difficulties with his father and with school, but was unable to mobilize herself to seek help. The mother expressed hostility toward her husband, whom she described as an unreliable, immature man who depreciated her, their married children, and Joseph. She acknowledged that, to compensate for her husband's behavior, she protected her youngest son and bore the brunt of the home pressures.

Because the school social worker felt that the marital conflict and each parent's behavior were adversely affecting the boy, he arranged weekly appointments with Mrs. Stern in the home, with Mr. Stern in his store, and with Joseph at school. Mr. Stern was the only family member who showed initial resistance to the contact. He interpreted the service as the kind given to a juvenile delinquent, projecting the blame for Joseph's difficulties onto the school and its personnel, but accepted the fact that the

worker would continue to see him. As the latter maintained contact, reassuring him as to his son's and his own positive qualities, he slowly accepted the worker and involved himself in the casework process.

Mrs. Stern was found to be a "martyr" mother who was overprotecting Joseph. She was finding it difficult to release him and permit him to face his home and school problems in a mature manner. Mr. Stern was an aggressive father who was fighting to assert his father and male role in the home and gain acceptance. His wife mistrusted him because he had been involved in an extramarital relationship many years earlier. Her negative attitude was reflected in the older children's feelings toward him.

Joseph, an obese youngster with bald spots, had a poor self-image. Because of continued school absences, he was academically retarded. He found it difficult to establish object relationships. In order to gain school peer recognition and acceptance, he acted out in class and defied his teachers when in school. He dreaded going to school and developed stomach upsets as a result.

As the contacts progressed, the worker noted that he was able to effect limited modifications with the parents. Although Mr. and Mrs. Stern's own attitudes toward each other did not change to any great extent, they were able to accept the school social worker's interpretations regarding the adolescent's needs for greater independence and male identification. Mrs. Stern drew back from the boy, while the father was able to move a little closer to him. The father took more of an interest in his son and even went to school to see a teacher when asked to do so by Joseph, something he had never done before.

The worker accepted Joseph's negative feelings about school and encouraged ventilation of his hostilities. After continued contacts the boy was able to express his desire for peer and teacher acceptance and his fear that no one liked him because of his obesity and inadequate hair. He also verbalized some negative feelings toward his mother because "she never let me fight my own battles with my father."

With the co-operation of his teachers, especially one male instructor, Joseph began to gain school satisfactions. He was given responsible monitorial tasks and began to show a sense of responsibility. As the school setting provided more satisfying experiences for him, his academic ratings became increasingly higher. Each report card showed greater academic and social gains. In his most recent marks, the boy had passed all his subjects and done well in those in which he had a particular interest. He attained a conduct mark of B+. In addition, he received more commendations than he had been given in his entire school history. He has never equaled his current attendance record, and has had an upset stomach only once in the past six months.

The school social worker's current plans include a medical study to determine a possible need for hormone therapy. He is now seeing each parent and Joseph on a biweekly basis. Continued service is planned to consolidate the gains made, to make service available to Joseph through the beginning of next school year, and to withdraw gradually as self-sustained adjustment becomes integrated.

SUMMARY

The authority of the school derives from society's desire to see that all children are enabled to develop to the best of their capacities. The school social worker, seen as an extension of the school, has access to highly resistive parents of school absentees and to the youngsters themselves. Parental recognition of the right and the duty of the school worker to visit them in their homes to discuss their child's problems helps them, over a period of time, to accept the worker and the casework service. This positive use of authority plays a significant role in bringing help to families who have avoided seek-

ing aid in spite of—and because of—their psychosocial involvements.

Client resistance to the school social worker's contacts must be recognized as a casework problem. In working with the multiproblem family, the worker must often prove that he is a genuinely interested and accepting person. Helping the family with pressing concrete needs has shown itself to be an effective means not only of establishing a firm client-worker relationship, but also of bringing an incalculable degree of stability to the home.

The advantages of the child-focused, family-centered approach provide the basis for the involvement of both parents, whenever possible, in the casework process. Experience has shown that drawing fathers into the problem-solving procedure most often leads to greater gains for all family members. Continued contacts with the multiproblem, hard-to-reach client will help practitioners to develop new skills and sharpen old ones, thereby insuring enriched service to people who surely need it.

COMMENTS ON CURRENTS

With this issue, the Editorial Board tries out a new department. Its members have pondered the problem for some time of how to bring the journal closer to the issues of the day—without at the same time affecting the quality of its contents, which necessarily must be based on enough accumulated practice experience to warrant analysis and publication. "Comments and Currents" will offer editorial discussion of such current issues—whether in social work or the larger social scene—by various members of the thirteen-man Editorial Board, in this way giving the reader the advantage of a broad range of talent, knowledge and interest.

—ED.

Social Action for the Sixties

THE ELECTION of 1960 now is history. The thirty-fifth President of the United States takes office with tremendous international and domestic problems looming ahead. To implement the challenge of the New Frontier requires the development of a broad and complex legislative program covering health, education, welfare, civil rights, housing, immigration, and other important areas.

Social workers have a special responsibility in 1961 and the years ahead to undertake a vigorous program of social action on behalf of such social legislation. This means that each social worker must become familiar with the issues and alternatives in medical care proposals, immigration and housing bills, and legislation affecting children and youth. Moreover, an intimate understanding of the legislative process is required to take constructive, timely, and efficient action.

During the fifties the climate of opinion was not conducive to the kind of social action that social workers engaged in during the first and third decades of this century. While social action has been retained in the social work curriculum, it holds a low priority today among the skills and interests nourished in the "professional" social worker. Yet, as before, the need for concentration on social policy and social action is a persistent everyday concern to social work.

To create and change social institutions better to meet human needs is not the task of a year or a particular decade. It is the opportunity of all times—times of calm and times of stress.

Arthur M. Schlesinger, Jr., in *The Crisis of the Old Order,* has written of how the social legislation of the thirties was realized as a result of the persistent social action of the two preceding decades:

> And for all the appearance of innocence and defenselessness the social workers' apparatus wielded power. "One could not over-estimate" observed [Senator Robert F.] Wagner, "the central part played by social workers in bringing before their representatives in Congress and State legislatures the present and insistent problems of modern-day life." The subtle and persistent saintliness of the social workers was in the end more deadly than all the bluster of business. Theirs was the implacability of gentleness.

The extent and depth of social action in the sixties will have consequential effects for many years ahead. The historian of the future may write that what social workers did or did not do in the sixties may have determined the course of human progress and social legislation for many years to come.

—W. J. C.

Rebuilding American Cities

A new era is facing the American city and its inhabitants—a planned reconstruction of our major metropolitan complexes. Much has been said in recent years about slum clearance, low-cost and public housing, the rush to the suburbs, and our new arterial highways. Until recently the rebuilding in the center of our cities has been premised on the desire to destroy substandard dwellings, with little regard for the social requirements of the people who are displaced. The move to the suburbs has, by and large, been directed and planned by the private builder, who has constructed individual dwellings efficiently but with little provision for the social requirements of suburban life. In either case social work agencies have had little to say about the character or direction of development.

Enthusiasm about buildings has lately been replaced by a concern over the goals of our rebuilding. This has found governmental expression in the federal programs for urban redevelopment with its provision of grants to municipalities for long-term metropolitan planning.

The piecemeal approach to low-cost housing in the center of the city, and unplanned private enterprise in the suburbs, have led citizens to consider whether their cities can be rebuilt more rationally and with greater attention to the human and social needs of the people who occupy and reside in these cities. In keeping with this development, social work is now being asked to share in the development of primary city policy, to help decide whether a given area should be redeveloped or renewed. In the process, social agencies are being asked very difficult questions: What consideration must be given to the existing neighborhood organization and interest of citizens? What health and social services are required for a given population? What open space and what public facilities will be required for various classes of residents. Social workers are hard put to specify the precise conditions necessary for healthy life in an urban center.

Despite this lack of explicit knowledge, city planning and housing officials are increasingly turning to social agencies and to social workers for help in defining the social components in urban development. The amount of exact progress is still limited, but encouraging signs are on the horizon. The National Social Welfare Assembly and the National Association of Housing and Redevelopment Officials have for several years maintained a joint committee on the relationship between social welfare and housing officials. In 1959, a new committee under the leadership of Sydney Markey of Philadelphia undertook to examine the long-range planning implications of these developments. In Baltimore and Philadelphia, the local welfare council staffs have worked closely with the city planning agencies to define social welfare standards essential for the planning of new areas to be redeveloped. In Boston, the Union of South End Settlements and the United Community Services

are each working closely with city planning and urban redevelopment officials on the depressed areas of the city. In Pittsburgh and Syracuse, among others, welfare councils have new plans for work with city planning officials. The Brookings Institute has recently undertaken a series of studies with groups of social scientists in Baltimore and Cincinnati to identify relevant knowledge in the social sciences which may contribute to improved planning. The Ford Foundation has announced a grant to NAHRO for a probing study of the way American cities are going about the renewal job—a study which will give special attention to the economic, social, and sociological factors as well as the geographical and technological ones.

This period of change raises for social workers in America a very real question. It appears that the time is past when their competence and skill will be limited to smoothing out the execution of plans already decided upon—meaning concentration on the after-effects of slum clearance, family relocation, and the provision of welfare services for minority segments of the population. Social work seems to be moving toward a major role in the rebuilding of the city. If social work is to grasp this opportunity, it must equip itself to provide firm standards and guides which will be respected by political authority as it goes about the task of developing comprehensive plans for the renewal and redevelopment of the core city. If the profession can contribute this kind of knowledge and information, it may well become another decisive voice in the shaping of basic plans.

Social work can do much to mobilize citizens to express their own views, but this is not enough. It needs also to develop clear thinking about objectives and programs consistent with its own *expertise*. Once this is developed, social welfare organizations must assume responsibility for strategy and tactics by which these goals can be achieved.

—R. M.

POINTS AND VIEWPOINTS

A Rationale for Directive Casework

Social casework has been proudly claimed as a uniquely American institution, and so it is. None of the western European nations with their considerable tradition of social legislation and organized welfare practice have evolved a similar concept of their own. Although during the first decades of this century they fathered the philosophical and clinical framework of modern individual-focused psychology, they did not see the need of applying this understanding to man as a social being. It was, rather, on the American scene that social casework was developed, and for good reason: it drew predominantly from those "in need," and in the urban setting of the time that meant largely from the group of the foreign-born or those raised in homes of foreign-born parents.

Many of them came close to the image of the penniless, non-English-speaking—possibly illiterate—largely unskilled immigrant, struggling for existence within one of the nationality neighborhoods of the large cities. Many were unaccustomed to an atmosphere of individual self-assertion against the authority of state and community, and —as a derivative—against the authority of the family. The progressiveness of the casework approach, its respect for the individual and his freedom of self-expression and self-determination, was an essential enabling factor in their adjustment to the American scene.

Yet the structure of the predepression American family and society as such, and even in the years just preceding World War II, remained sufficiently conventional and traditional to be supportive—to provide an effective guidance mechanism for its members. It remained a society in which the basic roles of all family members were defined clearly, with obligations and responsibilities spelled out comprehensively; a society preserving a time-honored, universally accepted code of distinct rules for the social and moral conduct of its members.

Subsequent years brought marked changes in the composition of the client group in social agencies. Casework services were not necessarily sought only by the "underprivileged." In counseling agencies, in clinical and school settings and so on, financial assistance ordinarily was no longer a part of services requested. The overwhelming number of agency clients by now were native Americans raised in fully or largely Americanized homes. In fact, whatever differences existed between the immigrant and indigenous population had lost much significance as the result of more universal foreign contacts on the part of Americans and the emergence of a more homogeneous Western and even the beginnings of a world-wide culture.

Simultaneously there was disintegration of the family structure, with its respected parental authority figures. The modern absentee father, at work, away from his family during most of its working hours, became too shadowy to serve as his household's central figure. Together with his mantle, many of his characteristics were inherited by the mother, making clear sex identification difficult for the children. Moreover, she too began increasingly to remove herself from the home in order to enter the work force, or to participate in the civic or social affairs of the community, thus lessening her impact on the children. A large and increasing

number of children were raised in one-parent families as the result of death, divorce, or separation, with the only parent often also fully absorbed in the task of the breadwinner. The lessened station of the father as the family's central authority figure was only partly compensated by increased significance in the mother's role. In sum total, the concept of parental authority suffered, and with it its effectiveness as a value-giving, standard-setting force.

As belief in the intrinsic rightness of parentally transmitted codes became weakened, their security-giving properties faded and disbelief gave way to rebellion and hostility. Generalized and intense, it was likely to be transferred to authority figures in the community at large hitherto universally respected: the schoolteacher, the police officer, the older person. No longer were they immune from attack by a generation from which they had ceased to receive respect or veneration as symbols of a continuum preserving values, standards, content.

At the same time, poverty and need concentrated in an "underprivileged" population segment—though far from being wiped out—was replaced by a more universal state of economic insecurity, affecting even those on relatively elevated standards of living. Social problems emerged as characteristic, not of material deprivation but of social and interpersonal pathology: marital and parent-child conflicts, previously less overt because of the more clearly defined images and roles of the members of family groups; juvenile delinquency, increasing among youths ready to accept the possibility of the straight and narrow path not necessarily being the most direct way of success in life in terms of "good and plenty"; readiness to dismiss the necessity of achievement, by accepting the philosophy that it does not matter *what,* but rather *whom* one knows; despair of justice, and willingness to substitute the might of the gun for right.

The profile of the social work clientele had changed vastly in many a setting of practice. Those seeking help now had in common that they were adrift, bewildered, perplexed about their roles in their families and in society. They were unable to navigate, because they had lost the beacons which a more clearly structured society had previously provided, with its values and its taboos. Adolescent rebellion was now often without a cause, since oppression and its symbols had already been shattered. It was more likely, rather, to mask a frantic search for new crutches by which one might walk steadily—for direction in keeping course, in a social climate which had lost the built-in guidance mechanism by which previous generations had oriented themselves. In such circumstances the traditional casework approach with its intrinsic nondirective quality was likely to become less effective, its basic rationale less generally valid. There was in many instances less reason to expect that a client gaining strength as a result of an effective casework relationship would be able to decide soundly, on his own, the "right," the "decent," the "proper," the

"honorable" (and so forth) thing to do in a world where standard-setting processes had atrophied around him, both within the family and in society at large.

In such a situation the superego-forming function might be expected to pass to others. In many instances the caseworker might feel called upon to represent community standards and mores more authoritatively and directly than had been the case in traditional practice. True, "directive," "authoritative," "assertive," or "aggressive" casework are not new in our professional armamentarium. But they had been utilized —or at least were likely to be reported in the literature—in a somewhat apologetic manner as a special tool reserved for the "hard-to-reach." The question arises whether, with today's group of agency clients and clinic patients, this type of casework must not be more widely and generally considered the professional tool of choice. If so, one essential qualification should be made: if the basic rehabilitative goal of the client's eventual independent functioning is to be achieved, directive casework can be utilized only temporarily, at crucial junctures of a casework relationship. Thus an authoritative role may be assumed and direction supplied only either in short-term contacts centering around the handling of concrete situations, or during critical phases of otherwise nondirective, sustained casework relationships.

Basically a directive short-term casework approach, used differentially and with skill, appears ideally suited to the intrinsic rehabilitative casework aim of helping the client to function on his own. It can be likened to the brief push which quickly enables a stalled car to travel again under its own power. It has qualities of parental authority which might be expected to exert impact normally provided by the ego, and particularly by the superego, were its functioning unimpaired. Professional resistance to directive casework methods may well stem from the caseworker's own well-developed professional superego—from a sense passed down by generations of caseworkers, which militates against utilizing a technique that might threaten a client's personal freedom of choice. Such basic conviction is essential to democratic processes in a democratic society. Equally important, however, seems to be the knowledge of when the use of a basic principle and approach ceases to be helpful and deviation from it becomes indicated in a given instance.

Moreover, there must be clarity as to when democratic processes are really at stake. Thus there appears to be an inclination to regard the family, for instance, as a miniature democracy—which it is not. It is not a political entity in which, as it were, parental authority is derived from the consent of those over whom it is exercised, or can be negated by their "majority decisions." Greek and Roman originators of democracy, the "rule of the people," logically restricted the concept to the area of the state, the *respublica.* Within the private structure of the family they retained the

concept of central parental authority through the paterfamilias in his capacity of the responsible head of the household. Nor is even society as such a political, specifically democratic entity in aspects reaching beyond the regulation of common affairs of community living. Its ethos, its collective values and mores, its sociocultural superego, developed by tradition and continually modified by current culture, are forces transcending political structure. Thus the social worker who injects himself authoritatively —who takes on a parental function or the representation of society at large—does not assume an undemocratic role. He does so rather as part of a helping process in which he temporarily provides—directly—a parental or societal superego quality. It is a technique which sensitive and secure caseworkers have always used; a technique which should be recognized more fully in its implications and potential as a significant tool in coping with today's client and his problems.

KURT FREUDENTHAL
Baltimore, Maryland

Statement on Corrections

This statement, from the Philadelphia Chapter, aims to clarify the role of professional social work in programs for the prevention and treatment of delinquency and crime.

Various correctional services exist in the community for the specific purpose of exercising authoritative control of the individual whenever necessary in the interest of the common good.

The obligation of organized society to step in whenever the acts of an individual citizen run counter to the social good is axiomatic. But advance in knowledge and insight, in the twentieth century, throws new light on basic psychological factors to be reckoned with when authoritative control becomes necessary. In the light of this new knowledge the limits of authoritative control in reshaping individual behavior to harmonize with the social good become clearer.

The primary operating objective of such control is to set definite limits so organized that the individual will be required to comply with them. Whatever limits are prescribed must allow room for the individual to exercise freedom, to make vital decisions of his own, to face his own problems and accept responsibility for his acts—constituting a combination of freedom and authority such as all citizens are subject to, and which is the very essence of democratic life.

In such a setting the individual may, through relationship with those skilled in the art of helping, find the strength to face reality, to muster power to make responsible choices, and to accept for himself the consequences of those choices.

Social work operates on the premise that the individual needs to make the most constructive use of himself and his relationships in order to nurture his own growth and more adequately achieve life fulfillment. The helping skills of social work are directed toward this goal. In every setting involving the relationship of the individual to his social environment, therefore, social work has a dual role to play.

1. At every point in the correctional process where the individual is faced with the necessity of examining his behavior as a responsible social being, the skills of the professionally trained and disciplined social worker play a decisive role.

2. The social work profession has an obligation to interpret to the community the true function and contribution of authoritative control by police, courts, and correctional agencies; the limits inherent in the authority vested in them; the consequences of abuse of such authority through disregard for human dignity; and the need for minimum standards of training and personal equipment on the part of those charged with the exercise of such authority, in order that these agencies may better serve the individuals who become subject to control.

H. DONALD BURR
Chairman, Committee on Corrections
Philadelphia Chapter, NASW

BOOK REVIEWS

AMERICANS VIEW THEIR MENTAL HEALTH. By Gerald Gurin, Joseph Veroff, and Sheila Feld. New York: Basic Books, 1960. 444 pp. $7.50.

This volume faithfully reports the findings of the first attempt to determine the nature and scope of adjustment problems recognized by the so-called normal adult population.[1] Further, it reveals the resources commonly used by the American people in coping with these problems—resources the individual has within himself, and those external resources to which he may turn.

Results of the survey may serve to confirm many of the notions that professionals have had about mental health problems; yet many of the findings will doubtless startle the reader, lay or professional. If this book can arouse the country's leaders at the national, state, and local levels to plan mental health programs based on knowledge gained, the intensive work of the surveyors will not have been in vain.

Part I, "Problems of Adjustment," deals with general adjustment and attitudes toward self and includes data on problems and behavior manifestations as they relate to marriage, parenthood, and the job. This section further relates certain demographic characteristics such as sex, age, occupation, and education to the prevalence of the problems revealed. Illustrative of findings are the following: older people tend to be unhappier than younger people, yet seem to worry less; men are largely concerned with external success—*e.g.*, in the business world—while women consider their interpersonal relations of greater importance; the more highly educated the person, the more happiness he finds in marriage, but also the more inadequate he feels; parents increasingly define their problems in psychological terms and thus should be increasingly amenable to the help that mental health practitioners can provide.

Part II, "Solving Problems of Adjustment," is of special significance for those in helping positions in that it throws light on why people go for help, where they go, how they choose resources, and whether they are satisfied with the help they receive. Among the findings are these: of the 2,460 persons interviewed, nearly one in four acknowledged that there had been times in their lives when they were troubled enough to need help, while only one in seven actually sought it; problems related to marriage and child-bearing, and to personal adjustment, brought the majority of help-seekers to a helping resource. Of those seeking help, 42 percent went to clergymen, 29 percent to physicians, 18 percent to psychiatrists or psychologists, and 10 percent to social agencies or marriage counseling services. The majority of those seeking help were looking for comfort and advice for what they considered problems outside themselves, while relatively few recognized internal problems and thus sought therapy.

Part III, "Summary and Conclusions," is a brief but provocative section, pointing up the practical implications of the study data. In the words of the authors, "We see the findings stressed in Part I particularly relevant for people in the mental health field who are working with problems in given population subgroups." Then with reference to Part II, "The distributions of help-seeking patterns and the uses of professional resources in the general population and in population subgroups . . . would seem to be information valuable to those attempting to formulate broad social decisions for meeting the mental health needs in the country."

ELIZABETH MCDONALD
Pennsylvania Department of Public Welfare

[1] Based on a nationwide interview survey sponsored by the Joint Commission on Mental Illness and Health.

SOCIAL WORKERS' PERCEPTIONS OF CLIENTS. A Study of the Caseload of a Social Agency. By Edgar F. Borgatta, David Fanshel, and Henry J. Meyer. New York: Russell Sage Foundation, 1960. 75 pp. $2.00.

This monograph is one of a steadily increasing flow of reports on relatively small but significant studies of specific aspects of social work knowledge and practice. Such studies are worth while for several reasons. Individual studies tend to confirm knowledge which has been arrived at empirically, but they frequently challenge some practices which have been based upon incomplete, inaccurate, or incorrectly understood data. In the aggregate, these studies add to the sum total of corroborated knowledge available to social work, suggest ways in which practice may be improved, and point to shortcomings in social work education as well as to gaps in knowledge which need to be filled.

Social Workers' Perceptions of Clients is a study of new clients who came to a large family and children's agency over a four-month period. Three categories of clients were studied: adult female clients, unmarried mothers, and adult male clients. The final sample selected for study consisted of 213 adult female clients, 59 unmarried mothers, and 59 adult male clients for a total of 331 cases. Unmarried mothers were placed in a separate category because the reasons which impel them to come to a social agency, as well as the practical needs to be met, sufficiently distinguish them from other adult female clients to warrant a separate category for study.

The monograph is divided into three chapters. The first two, "The Caseload of the Agency" and "The Structures of Perceived Characteristics of Clients," are concerned largely with the methodology employed, a presentation of the findings, and an analysis of the findings. These two chapters and the appendices take the reader rather fully into the techniques and complexities of the research procedures used. The relatively unsophisticated reader (in which classification this reviewer places himself) will find that the semitechnical terminology and the careful writing call for the kind of concentration which is not always required for other reading.

The third and final chapter, "Studying the Caseload and the Casework Enterprise," draws generalized implications suggested by the study. The incompleteness of information about general characteristics of the population—especially the absence of agreement as to what characteristics and kinds of behavior are desirable—is pointed up as a particular problem confronting research efforts. The authors' classification of information about clients under the headings (a) background information, (b) attitudinal or covert behavior, and (c) manifest behavior information is presented cogently and provocatively.

Although the study has limitations and omissions which the authors frankly recognize, it nevertheless uncovers, in a benign but penetrating way, a number of questions about social workers' perceptions of their clients.

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PSYCHOANALYSIS AND THE FAMILY NEUROSIS. By Martin Grotjahn, M.D. New York: W. W. Norton & Company, 1960. 320 pp. $5.95.

Dr. Grotjahn views current experimentation in family treatment as a most promising variation in psychoanalytic therapy. The neurosis of the individual may be in response to, and maintained by, the complementary neurosis of another person, or the specific neurotic structure of his family group. In like manner, the family neurosis may be an extension of the disturbance of one of its members. Therefore psychoanalysis of the individual may remain incomplete and may fail, unless the analyst also treats the family. Psychoanalytic family treatment may occur through therapy of (a) the individual patient, (b) one additional person, or (c) the family as a group. Besides using analysis of the bipolar transfer-

ence neurosis, characteristic of individual psychoanalysis, the therapist may employ also a triangular or polygonal approach involving directly the patient's mate or his family. Discussions, rich in illustrative data, give attention to the psychodynamics of health and complementary neuroses in the family; to aims, limitations, and dangers; and to other technical aspects of psychoanalytic family therapy. Some readers will search the book for more specific delineation of methods. The author, strikingly cautious (perhaps because of concern over departure from familiar orthodox Freudian psychoanalytic orientation, perhaps through apprehension lest treatment be undertaken by analytically unqualified therapists), asserts that—as yet—practical knowledge is insufficient for a systematic presentation of technical formulations.

To SOCIAL WORK readers, many points relating to diagnosis as well as treatment will be received in a manner not unlike the reaction of the seasoned traveler who revisits familiar territory. This will be notably so for caseworkers in family and psychiatric agencies, and for some workers in social group work, who, like family physicians, are accustomed to taking psychosocial forces into account in understanding and helping the individual, in assisting the family through him, and vice versa. Acknowledgment of this is voiced by the author in a terse reference to family welfare agencies who greet this Johnny-come-lately with the remark, "I told you so, but you were not listening," and by his concluding plea that "a combination of the old tradition of the family physician and the modern tools of psychoanalysis will allow the new analytic family therapist to view the future with faith and hope."

Dr. Grotjahn, in company with other recent investigators, makes a valuable and a provocative contribution to a widening search for more efficient methods of psychoanalysis.

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CHARACTER DISORDERS IN PARENTS OF DELINQUENTS. By Beatrice Simcox Reiner and Irving Kaufman, M.D. New York: Family Service Association of America, 1959. 179 pp. $2.75.

In this book the authors present their formulations about the diagnosis and casework treatment of those adult clients who can be classified as having pregenital character disorders. In several important respects, the formulations by Mrs. Reiner and Dr. Kaufman, which are based on a five-year research project, represent an advance over many of the previous attempts in social work to develop differential diagnostic and treatment formulations for specific types of clients. Particularly commendable is the extent to which the authors attempt to state explicitly and in detail how their treatment formulations are related to their assumptions about the behavior of this group of clients.

The first third of the book consists of an exceptionally clear review of Freudian theory pertaining to oral, anal, and phallic-urethral character disorders, content that should be familiar to most caseworkers. Since the authors chose, by design, to develop their diagnostic and treatment conceptions within an exclusively psychological and classically Freudian frame, they can hardly be criticized for slighting factors that they deliberately chose to ignore, such as the sociocultural and social-psychological determinants of behavior. Unhappily, the recognition that they omitted "other, equally important" factors (p. 4) does not prevent them from implying, throughout most of the book, that their psychological assumptions provide a complete and sufficient explanation for the behavior of this group of clients. Further, the adherence to one theoretical framework, combined with an unfortunate tendency to regard hypotheses as facts, fosters some very doubtful conclusions, of which the following statement is one example: "Persons who are at the bottom of the economic scale . . . in the main, are in this position because of personality difficulties" (p. 171).

The most intriguing parts of this book are the chapters on treatment. This section contains a number of imaginative and creative ideas that merit further study, experimentation, and elaboration by caseworkers. Examples of these ideas are the descriptions of attempts to modify the concepts that the client applies to himself and others, the discussion of special features in the casework relationship with clients of this type, the analysis of communication between caseworker and client through actions rather than words, and the emphatic suggestions that the caseworker should be encouraged to experiment in treatment, provided he knows why he is experimenting.

The authors set forth and describe four stages in the casework treatment of character disorders. However, the clinical evidence provided for the universality of these stages in the treatment of such clients is not entirely convincing. For example, the book gives the impression, which may not be accurate, that only one, or possibly two of the clients studied had completed all four stages of treatment. If this is true, then firm generalizations about all clients with character disorders are hardly justified. Similarly, the authors weaken their thesis by concluding, presumably on the basis of their experience with female clients, that their formulations are equally applicable to men, even though very few men were included in the study. With reference to such questions, some statistics about the clients in this study, including the number carried through each stage of treatment, would have been helpful.

In spite of the limitations mentioned, this book is a welcome contribution to an area of casework practice, where knowledge is urgently needed. All caseworkers should read this book. Many caseworkers will find it helpful in the treatment of clients; it is to be hoped that it may stimulate some of them to conduct additional studies of this type.

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JUVENILE DELINQUENCY, ITS NATURE AND CONTROL. By Sophia M. Robison. New York: Henry Holt and Company, 1960. 546 pp. $6.75.

To any student interested in the field of juvenile delinquency, Miss Robison's volume must be required reading. In her 532 pages she has covered the various definitions of delinquency, the most generally accepted schools of thought as to its cause, the legal agencies and institutions dealing with the juvenile offender, and the various programs to prevent delinquency. In her final section she very adequately sums up what has been thought of and done about delinquency until the present time, and uses this as a springboard for approaches which might be more effective in the future. In summary, she does not think that any particular school of thought, agency, or program has been really effective in this field, although some have had limited success.

Starting with the point that we really do not know who the delinquents are, since the juvenile courts get such a small proportion of actual violators, the author suggests the establishment of a central register in each community to identify children who are engaging in behavior intolerable to the community. This, she believes, will give us a broader basis by which to test our knowledge of these children.

The author's section on theories of causation of delinquency, which is the longest in the book, examines the principal schools of thought concerning the causes of delinquency. From her researcher's point of view, Miss Robison is critical of all these schools. However, she does believe that each has added to our sum of knowledge of delinquency, and that, rather than trying to ascribe delinquency to one cause, we must be willing to accept that the behavior of children is influenced by many causes.

In Parts 3 and 4, an attempt is made to evaluate the work of the police, the juvenile courts, and institutions to which delinquent children are being committed. With all three of these instruments of public policy,

the author finds that unclear definition of role, lack of adequately trained personnel, and inferior plant facilities are factors in limiting the effectiveness of these agencies to help children.

Programs set up in response to the belief that "an ounce of prevention is worth a pound of cure" also come in for critical review. Miss Robison reviews the efforts that have been made by community councils, increased services to individuals, and the detached worker programs. She admits that there have been some successes, but none of these programs have demonstrated that it is *the* answer to delinquency.

If it should appear that the author is unduly critical of all the efforts made to prevent delinquency and treat the offender, we need to return to the purpose of this book, stated in the preface: "The purpose, in what may appear to be a critical approach to much current theory and practice, is not to tear down, but to try to penetrate fogs." Miss Robison offers no final answers, but has attempted, by showing the gaps in current knowledge and practice, to work in the future: ". . . to better definitions, new insights into cause and more effective ways of dealing with so persistent a social problem as juvenile delinquency." In her concluding chapter she urges, in effect, not to be discouraged, but to seek out more of these disturbed youngsters and the reasons for their problems; to make better use of our agencies and their personnel; and finally, to improve our research methods in this field.

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THE SOCIAL PSYCHOLOGY OF GROUPS. By John W. Thibaut and Harold H. Kelley. New York: John Wiley & Sons, 1959. 313 pp. $7.00.

Thibaut and Kelley's new book is not just another volume in the rapidly increasing library on group dynamics. In fact, it differs in several important aspects.

To begin with, it is not, as is customary in that field, a collection of papers or research reports, put together by an editor and arranged under various headings. Rather, it constitutes a unified presentation of ideas pertaining to the interaction of individuals. It begins with a few simple, clearly spelled-out concepts. These simple concepts are then applied to a variety of situations and are illustrated or validated by relevant research findings or pertinent theoretical formulation of other authors. This highly disciplined approach leads to a soundly planned and well-structured work. The authors visualize the main purpose of the book to be a basic text in social psychology. The influence of up-to-date learning theory can be noticed, not only in its skillful integration throughout the content but also in the organization of the material itself. This should indeed then make it exceptionally well suited for use as a text in a beginning course in social psychology.

The second distinguishing factor lies in the object of analysis itself. Contrary to what the title suggests, a large portion of this book—in fact, two-thirds—deals with the one-to-one relationship, the "dyad." The transition from this pair construct to the larger and more complex group consists of an application of dyad principles to the three-person or "tryad" formation. Other concepts of group phenomena are discussed on a limited but selective basis. The chapters dealing with norms, roles, and especially with conformity are among the best, in the estimation of this reviewer.

In essence the authors view interaction between two individuals as a sequence of mutual stimulations and responses. For each participant this leads to outcomes which are measurable in terms of degrees of the reward or cost. In order to maintain a voluntary relationship, the rewards must be higher and the costs lower, as compared with other relationships in which one is involved currently. This comparison level, or CL, becomes the vital determinant in entering and maintaining voluntary relationship.

In one chapter the authors make an interesting application of these ideas to nonvoluntary relationships, as in prisons, concentration camps, and so forth.

Evaluation of a relationship can be made by putting the outcomes per item for each partner on a four-cell table. The partner who has more choices available and whose CL is higher will generally be less dependent on this particular relationship. He is therefore in the position to control the other person. The authors make an interesting distinction between "fate control" and "behavior control." The development of this formulation is stimulating and should prove useful in the understanding of certain relationships and changes occurring in them. In fact, all the concepts per se contain this stimulating and potentially useful element. Yet, for the person who deals professionally with the intricacies of human relationships, be it on a dyadic or more complex basis, the whole approach appears—frankly—naïve. It touches only those overt aspects of interaction which can be easily analyzed in a necessarily somewhat mechanistic manner.

Using the author's concepts, it would seem that the costs of reading this book are rather high. It demands concentration, frequent recall, and attention to detail. Its immediate applicability to social work practice is questionable. For the theoretician or the teacher, however, the rewards may well outweigh the cost. Social group work teachers, or those who want to arrive at clearer formulation of group processes, will find certain parts of it pertinent, clear, and helpful. This reviewer responded in ways that kept the outcome above her CL by forcing her to clarify some of her own concepts, through internal agreement or argument with the authors, and it presented her with some valuable new ideas. For like-minded readers, study of the book should be a rewarding experience.

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THE HEALTHY CHILD. HIS PHYSICAL, PSYCHOLOGICAL AND SOCIAL DEVELOPMENT. Edited by Harold C. Stuart, M.D. and Dane G. Prugh, M.D. Cambridge, Massachusetts: Harvard University Press, 1960. 507 pp. $10.00.

We are indebted to both Dr. Stuart and Dr. Prugh, who also contributed to the text, for bringing together materials used in a series of institutes on child growth and development given by the Department of Maternal and Child Health of the Harvard School of Public Health. Twenty-two distinguished members in the fields of health, psychology, social work, and education each have contributed one or more articles, forming an orderly and comprehensive presentation of child development from the fetal to the adolescent stage.

The authors, each from his separate discipline and knowledge of children, have in general a common point of view: seeing the child's growth and development as a continuous process. They recognize the normality of individual differences in rates of growth and degrees of change in development; accept the validity of the interaction between environmental and genetic factors in the child's life; point out that the child's family experiences and cultural milieu influence his development toward physical, emotional, and social health; stress community responsibility for providing adequate services to all children; and repeat that more research is needed to increase our present knowledge of child development and to improve services to ensure opportunities for each child within his capacities. This makes for some repetition.

It is not, however, a book to be read at one sitting. This is a reference book for all workers in the fields of health, welfare, and education, and the authors presuppose considerable background knowledge on the part of the reader. Their approach is practical, reassuring, and at the same time challenging.

A social worker is not competent to comment on details or specifics reported by the

contributors from other fields. For social workers, however, there is much valuable information for understanding and treating children—particularly for caseworkers with children who must be cared for away from their own parents, either in foster care or in hospitals. Adoption workers also should get considerable help in their ability to evaluate the infant for early placement.

On the whole, the articles are well written and thought-provoking. The references appended to the volume are in themselves a valuable contribution to the professional worker in any of the disciplines. Certainly this book should be in the library of every professional worker with children.

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INTERNATIONAL CO-OPERATION FOR SOCIAL WELFARE—A NEW REALITY. The Annals of the American Academy of Political and Social Science, May 1960. Special Editor, Hertha Kraus, Ph.D. 153 pp. $2.00.

Here is a publication worth owning, marking up, and using. For facts and their significance about international welfare activities, this issue of the *Annals* has an encyclopedic character. Its major importance for all social workers rests on the presentation of an emerging emphasis, stated clearly by Walter Kotschnig of the U.S. Department of State in his article "Social Development and Foreign Policy": "... in word and deed it must be made clear that the very purpose of economic development is a social objective."

Thanks to the initiative of the Philadelphia Area NASW Committee on International Social Welfare and to the work of Dr. Hertha Kraus as editor, this *Annals* has contributions from sixteen authors, many of them our colleagues, who are well acquainted with international economic and social needs and programs. Included is theoretical as well as specific topic content which offers perspectives for judging the major problems of our time and the efforts made by international, bilateral, national government, and voluntary groups. The vast scope of need and range of programs are glimpsed in the concise writing, fact-packed pages, and vivid viewpoints which, while varying, are agreed that too much importance has been attached to economic progress alone, assuming falsely that social improvements will automatically follow. The brevity necessitated by such a volume may overwhelm both beginners and old hands with this material, but excellent references also make a quickly available bibliography for further reading.

Social workers have long voiced concern for "social development." Now, applied to international aid, these presentations give the substance for a concerted effort by NASW chapters and members in several areas: (1) active support for extended and expanded implementation of *social* aspects through ICA and in the U.N. Economic and Social Council, and by revision of the 1954 Mutual Security Act (Title III, Section 302) to include social services; (2) action in support of the assignment of social attachés to U.S. embassies and missions, especially in Latin America, Africa, and southeast Asia; (3) assistance in securing and preparing personnel for short and long-term international assignments; (4) attention to strengthened U.S. social work practice in interdisciplinary activities, particularly with agricultural and political colleagues.

Social workers know that, for individuals, "democracy begins somewhere above 1900 calories per day." Social workers also know that international co-operation is necessary because of the worth and dignity of human beings, not because it will deter communism. Economic and social development, interrelated, are the business of social workers. The May 1960 *Annals* can be a resource for our long-delayed contribution as agents of social change in the international arena.

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LETTERS

CRITICISM OF THE JOURNAL—AND NASW

Speaking to the American Association of Social Workers in 1926, Porter R. Lee said, "Our greatest need is a procedure within this association which will stimulate study and discussion of professional problems by its membership." More recently, in 1954, Arthur P. Miles in his book *Social Work Theory* admonished that a theory of social work "must explain social work as it operates throughout the country and not be limited to restricted services or cities." Other prominent names in social work have questioned our provincialism; still others have wondered if social workers were competent in solving problems in their own field.

Considering Porter Lee's comment—our professional journal is not stimulating study and discussion of problems through articles. Procedure for submitting articles is quite complex and limits us to what we *should* submit rather than encouraging us to a free expression of thoughts. Instructions for submitting articles were printed in February 1959 Newsletter.[1] This type of selection of articles seems to be based on a party-line concept of what will appear in the journal.

A perusal of seven issues (April 1958–October 1959) of SOCIAL WORK will reveal that of 99 articles 48 came from cities not more than 250 miles from New York City—and 29, or one-third of the 99, came from New York City. A further look at this problem reveals that in the seven issues (July 1956–January 1958) preceding those just mentioned above, 30 or over one-third of the 89 articles that appeared were from New York City. An underlying deficiency also is evident when one looks for articles from schools of social work. Whether the journal should reflect such representation might be argued, but the fact that of 27 school articles, of the 99, 11 came from two schools (7 from the New York School, 4 from Western Reserve) leads one to wonder why 44 schools of social work were not heard from in almost four years.

Perhaps those of us who talk about provincialism are not really awakened to its degree of contamination. As yet no single article, paper, book, or other form of instruction has made social work as practiced in the great metropolis any more effective or successful than that practiced in remote parts of our country. Why then should we be subjected to the preponderance of theory and practice emanating from that locale? Its membership is approximately 10 percent of the total NASW membership.

Certainly when the competence of social workers is appraised we are not generally good, effective, tactful writers (or perhaps not good party-line observers). Nevertheless, the journal is avoiding some basic problems by excluding articles that deal with such controversial subject matter. At a time when government, education, and even medicine are signaling a greater loss of individual thinking and expression, it ill behooves social workers not to stem the tide and practice what they preach. How can we hope to help people to express themselves or act independently when we ourselves are giving such valuable possessions to a "national establishment" which will not quickly or possibly ever return those valuable possessions?

Soon a delegate's convention will further "centralize" responsibilities for us that should remain with our local chapters. Soon social workers will only be recognized

[1] This apparently refers to specifications for Research Section articles as set down by that Section's Publications Committee. For suggestions by the Editorial Board for articles under its jurisdiction, *see* SOCIAL WORK, Vol. 3, No. 1 (January 1958), p. 2 and Vol. 5, No. 2 (April 1960), p. 2 and the masthead on the inside front cover of the journal—ED.

if they are NASW members. A phantom organization (an academy) with officers the same as NASW officers will emerge to monopolize further our valuable possessions and contaminate our moral system, to say nothing about extra monetary assessments.

Porter Lee and Arthur Miles give us fair warning. Lee also maintained that, "in the long run the standards of social work will be safer in the hands of social workers themselves than in the hands of organizations."

Are we ready and willing to turn over our most valued possessions and tools to an organization that cannot or will not tolerate other views?

Relegation of the problem to the letter to the editor section does not minimize the problem. It points out a reluctance on the part of the national establishment to treat the problem and causes one to wonder why this space was guaranteed to "air" it.

HOWARD PARKER

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CONCLUSIONS ON FEE CASES APPEAR UNJUSTIFIED

The conclusions of Mr. Nathaniel Goodman in his provocative article on fee and non-fee cases (October 1960) appear misplaced on the basis of his data. Mr. Goodman interprets his findings to show that "fee-paying clients . . . tend disproportionately to continue" (p. 50) and therefore concludes that casework in his agency is more effective with these fee-paying clients. His key supporting data are that in 1955–56, 35 percent of fee-paying cases received four or more undercare interviews compared to 27 percent of the non-fee cases (Table 3, p. 49).

If I read his data correctly, the more accurate figures would be 55 percent continuing fee-paying cases in 1955–56, compared to 57 percent continuing non-fee cases. Should not the percentages of continuing cases (Table 3) be based upon the pool of undercare cases, which in turn are only a portion of those applying for service? The more appropriate ratios would then appear to be 47/85 and 76/134 continuing fee and non-fee cases respectively.

The only other method which would appear to lend itself to the author's purpose would be to compute the proportions of continuing fee and non-fee cases relative to those provided the agency opportunity to continue, *i.e.*, those cases accepted at intake and assigned to undercare. In this latter instance, the relevant ratios are 47/112 (42 percent) continuing fee-paying cases in 1955–56, and 76/134 (47 percent) continuing non-fee cases.

By either computation, the policy implications of Mr. Goodman's interpretations and conclusions might then be opposite to those which he so lucidly outlines.

HERMAN PIVEN

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AUTHOR'S REPLY

Mr. Piven's first set of proportions—47/85 and 76/134—would answer the question: What is the difference between fee-paying and non-fee-paying clients who have been selected for and do agree to go on in continued service and who actually begin continued service?

Mr. Piven's second set of proportions—47/112 and 76/163 (his 76/134 is an obvious error; see my Table 1, Column 5, Line 1)—answers the question: What is the difference between fee-paying and non-fee-paying clients who have been selected for and do agree to go on in continued service?

Both are interesting questions but not the concern of the article, which was: Are there differences between fee-paying and non-fee-paying clients relative to the size of the respective pools of continuers produced by each group? Put in another way: Is a fee-paying client more likely to become a continuing client than a non-fee-paying client?

Mr. Piven's proportions relate to the question: Is a fee-paying client selected for and

agreeing to continued service more likely to become a continuing client than a non-fee-paying client similarly selected?

Mr. Piven's proportions answer a more restricted inquiry. I would agree that the data seem to indicate that there is little difference of effectiveness relative to the client's fee status among those clients selected for and agreeing to continue—*but* fewer non-fee-paying clients seem to get into this selected group.

NATHANIEL GOODMAN

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VIEWS ON ALCOHOLISM

I want to offer to you my congratulations for publishing the two articles on alcoholism.

If social work and the other helping professions do not very soon embrace alcoholism in the area of their operations, we are going to see a rise of an unnecessary new group of specialists competing for attention and support and slicing up human problems into unnecessarily small segments.

RALPH W. DANIEL

Executive Director
Michigan State Board of Alcoholism
Lansing, Michigan

After reading the current issue of SOCIAL WORK, October 1960, I felt compelled to write the following comment.

The article which disturbed me and which I felt compelled to amplify on is entitled "Alcoholics Anonymous As a Community Resource," by John Park Lee. The point I wish to raise about this article is the implication to refer the alcoholic rather than to try to involve him in a treatment relationship. I personally subscribe to the view that alcoholics are sick people. They are psychotic, borderline psychotic, or extremely disturbed character disorders. Sometimes a patient is healthy enough to be diagnosed as a neurotic. The alcoholic has a strong part of himself which likes his symptom (drinking), and does not want to change. The other part, which brings him to a clinic, is the stronger one which wants help. Help, of course, to these people can mean anything, and one rarely finds a patient who can involve himself in a relationship with a therapist in which the patient is willing to face his part in provoking his life experiences that are so disturbing to him. The relationship the alcoholic can make, as many have pointed out, is so tenuous that to refer him is also to reject him.

Of course the frustrations social workers encounter in dealing with the alcoholic stem from the complexity of the problem itself. Bailey and Fuchs touch on this when they raise questions of goals. Myerson has gone further in delineating some goals which can be achieved. Theiman and Price brought out long ago the place of the therapeutic milieu used in dealing with alcoholics. I could list others who have published ideas and experience, all dealing with important aspects of working with alcoholism.

While I am not suggesting that we deny a person his inalienable right of choice, I raise the question of whether the frustrations we feel should be handled by referral to a group where professional, disciplined people are in no way involved or should we continue to try to understand more, experiment, and develop our techniques, build our programs, and in the future, as a profession, become more effective in our work with this group. I think the answer is obvious.

MONROE D. GREEN

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